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The Journal of Cutaneous Diseases

Including Syphilis

OFFICIAL ORGAN OF THE
AMERICAN DERMATOLOGICAL ASSOCIATION

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GEORGE M. MACKEE, M.D., New York, Editor
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INCLUDING SYPHILIS

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXXV SEPTEMBER, 1917 NO. 7

Address

AMERICAN DERMATOLOGICAL ASSOCIATION

TWENTY-FOURTH ANNUAL MEETING, HELD AT CINCINNATI, OHIO, MAY 24-26, 1917

PRESIDENTIAL ADDRESS

A. RAVOGLI, M.D.
CINCINNATI

The honor of opening this meeting has devolved on me, and I assure you that I feel greatly pleased and more than proud to open the first meeting of the Association in Cincinnati. It is a most pleasant duty to greet you and the Association in my home city. I will not deviate from the custom observed by our Association to give a short address concerning the meetings, the works and the progress in the field of dermatology, the subject of our studies.

In our present advanced state of culture, with our knowledge of histology, pathology, chemistry, bacteriology and serology, and with many years of clinical experience, it will be of some interest to look back and see what the American Dermatological Association has accomplished in the period of forty-one years.

In July, 1876, the American Dermatological Association was conceived and on September 6 was organized at the University of Pennsylvania, at Philadelphia, with Drs. Bulkley and Fox of New York, secretaries pro tem., and Wigglesworth of Boston, chairman pro tem. At the first meeting, fourteen members were enrolled, the constitution and by-laws were proposed and adopted and Dr. James C. White was elected president. The membership reached 29; the meeting was adjourned to hold its first annual session at Niagara Falls, on the first Tuesday of September, 1877. The president, Dr. White, opened the meeting by an address entitled, "A Review of the Progress of Dermatology in America for the past Twenty-Five Years, and the Gradual Recognition of this Branch in the Colleges of the Country."

At the third annual meeting, held in New York, Dr. Duhring, the chairman, read an address on "The Rise of American Dermatology." The interesting feature of this meeting was that on the afternoon of the last day the Association met at the New York Hospital for a clinical inspection of cases.

It is a great satisfaction to look back on the period of forty years and see the difficulties which the Association had to overcome and what it has overcome. As Dr. White said at the second annual meeting in Saratoga Springs, the principal faults in American dermatology were the lack of a uniform classification and nomenclature, and the lack of statistics. Two committees were appointed to work on these lines and the results of their work, incomplete as they were, laid the foundation of the Association and insured its perpetuation.

It was at that meeting that a classification and nomenclature were proposed and adopted. The classification was in general based on that of Hebra, but it aimed to reduce the number of groups and to strike out a number of subdivisions, placing others in a more appropriate category. The system was more simple than Hebra's and yet broad enough to embrace every special variety of disease.

By vote of the members, on the recommendation of Dr. White, the system of classification and nomenclature was adopted as the official code of the Association.

At the same time a permanent committee on statistics was appointed for the purpose of collecting data, to aid in the study of the prevalence and character of the skin diseases in the United States. A member was assigned to each district, with the request to send reports of all cases observed in private and dispensary work. Appropriate blanks were sent by the member supervising the district to all those who made the treatment of skin diseases a specialty, and to all those who had charge of dermatologic clinics and dispensaries. In the first report appeared a collection of 30,000 diseases, well recorded and tabulated. The statistical report is followed by a report from the same committee dealing with leprosy in America. As is the case today, leprosy was found in foci among the Norwegian colonies in Minnesota, among the blacks and Jews in South Carolina and the Gulf States, and some sporadic cases in our Northern states. The most interesting feature deals with the lepers found among the French residents of northeastern New Brunswick, from which point leprosy was spread to Providence, Rhode Island.

From the report it would seem that the cases of leprosy appeared to persist in the descendants of various families to such an extent that the resident physicians believed the disease to be hereditary, while one

Dr. Gordon maintained it to be contagious, having seen individuals of different races, living in leprous families, become infected.

It appeared from that report that a lazaretto had been established under the care of Dr. A. C. Smith, but since 1868 medical attendance had been discontinued, the patients remaining under the care of nuns of the Hotel Dieu of Montreal and of the chaplain, leaving the patients for twenty years without medical observation. This had deprived the profession of valuable data regarding the disease.

In the same report Dr. Atkinson gave an interesting account of leprosy in the Southern Atlantic States; Dr. Hyde, of leprosy in Minnesota. The incidence of leprosy in California and at the Sandwich Islands was taken from reports of the Health Officers, as narrated by Dr. White.

The committee on nomenclature, by establishing a uniformity of names of the diseases of the skin, obviated the difficulties attending the use of different names for one disease, so often the cause of confusion. The committee on statistics was able to show the prevalence and the character of skin diseases in the United States. The observations represented mostly the diseases of the skin in large cities, but when we consider that patients from rural districts often consult, or are referred by the family physician to a specialist in a large city, this represented a wider area than the city from which the observations were derived.

As Dr. Duhring said, the importance of collecting and preserving facts in connection with whatsoever department of science, cannot be overestimated. The hardest thing is to get possession of facts, and on them build the scientific structure. The progress of science is largely dependent on the character and the accuracy of the observations, and in no other branch of medicine are reliable observations so needed as in the study of dermatology. Scientific methods of research have now been introduced in our studies and much has been learned. A great many diseases have been made clear and have been found to be the result of general affections of the system, or local results of the action of bacteria or of fungi.

With the best of intentions, individual minds differ so much on account of their education or experience, that the views of two observers on the same subject will be at variance. It was, therefore, a great forward step when this Association began to devote time to the demonstrations of patients, illustrations and pathologic specimens, which part of the program has always been attended with success and has made one of the most interesting features of our annual meetings.

The report of carefully studied cases of unusual affections, controlled by accurate observations, with the application of laboratory tests and of appropriate therapy, increases our knowledge, stimulates

our diagnostic ability and is a guide for future observations in our practice. It is therefore commendable that, together with our scientific meeting, one or two sessions are given to the demonstration of patients and to the full discussion of the cases.

If we wish to look into the past we can find memoirs and works of physicians who, we can say, gave birth to American dermatology. To my mind it would be better to say dermatology in America, for the reason that science is international, has no boundary of countries nor of languages. Yet when others speak of a German, French, Italian or British dermatology, we too have to say American dermatology. Dr. Duhring, in his presidential address, Aug. 26, 1879, referred to all the works published in America on diseases of the skin. Indeed, no country can go very far back in dermatologic knowledge, because dermatology, until the time of Plenke, Willan, Cazenave and Schoedel, had no right to be called a science. We find that such an eminent man as Benjamin Rush in America, stated that leprosy, elephantiasis, scurvy and venereal diseases appear to be but different modifications of the same disorder, and that the same causes produce them in every age and country.[1] This subject, however, was not far advanced even in other countries, as Turner's work, full of crude observations and of the superstitions of his day, at the same time formed a standard work in England. In reference to syphilis, which had been prevalent in this country for over a century, we must make reference to Thomas Thacher,[2] who wrote that syphilis made its appearance in Boston in 1646. The people of Boston were very much concerned with the appearance of a disease with which they had not been acquainted. It originated in the wife of a seafaring man, who after childbirth was affected with an ulcerated breast. Many persons were employed to draw this woman's breast, by which means about sixteen persons, men, women and children, became affected with this odious disease.

Remarkable theses on subjects related to dermatology were presented in the University of Pennsylvania, which at this time had already risen to a conspicuous position as a seat of learning. Worthy to be recorded are Magruder on smallpox, Williamson on scarlet fever, Huger on gangrene and mortification, Condict on the effects of contagium on the human body; but the most important of all was that of Horsfield, "An Experimental Dissertation on Rhus Vernix, Rhus radicans and Rhus glabrum, Known as Poison Vine, or Comroson Summach."

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1. An Inquiry into the Natural History of Medicine among the Indians of North America. An oration delivered before the American Philosophical Societies. Phila., 1774.

2. Thacher, Thomas: Am. Med. Biog., Boston, 1828.

Essays and experimental works were made on the physiology of the skin, by Agnew of Princeton, and on perspiration and on absorption of the skin, concerning particularly the absorption of mercury in the treatment of syphilis.

We come now to Jenner's introduction of vaccination for the prevention of smallpox. Early in 1799, the great discovery was made public by Baron, in his "Life of Jenner." Benjamin Waterhouse,[4] professor of theory and practice in the University of Cambridge, inoculated seven of his own children with the cowpox virus obtained directly from Jenner. The following year he wrote his well known brochure, "A Prospect of Exterminating the Smallpox, Being the Discovery of the Variolæ Vaccinæ or Kinepox." Vaccination attracted a great deal of attention in this country, and a large number of pamphlets have been written on the interesting subject.

I must mention that in the first decade of the last century two Boylston Prize Essays were published; one on the subject of mortification, and the other on the "Structure and Physiology of the Skin, with a View to the Diagnostics and Cure of Diseases Usually Denominated Cutaneous." The author of the second was George Cheyne Shattuck, of Boston. The work is based entirely on his own observations and lacks any reference to earlier writers. Yet the work of Willan, which had been published in 1798 in London, and copies of which had probably been brought to America, is entirely ignored.

At this time foreign works on diseases of the skin were introduced in America. Hunter's "Treatise on the Venereal Diseases, with an Introduction and Commentary by Joseph Adams," Bateman's "Practical Synopsis of Cutaneous Diseases," Carmichael's "Essay on Venereal Diseases," etc., all appeared between the years 1818 and 1830. The literature of those times was very scanty in all subjects, and in reference to dermatology it was limited to a few observations, published as curiosities more than for scientific purposes, like Haskell's,[4] "Ichthyosis Cornea," a case of a negro whose skin became white, etc.

As Duhring so well stated, those were dark days for dermatology; the whole subject was shrouded in mystery, and it would seem was judged either too obscure or as being too insignificant to be worthy of serious attention. Lack of opportunities was no excuse, for much had been accomplished in England through the works of Willan and Bateman.

The first step in the study of dermatology in this country was made when on June 22, 1836, the Broome Street Infirmary for diseases of the skin was opened in New York, with Drs. H. D. Bulkley and John

3. Waterhouse, Benjamin: Boston, 1800.
4. Haskell: New England Journal of Medicine and Surgery, 1819.

Watson as physicians in charge. In this infirmary Dr. Bulkley delivered a course of lectures on diseases of the skin, which were the first in this country. The lectures continued for three years at the Broome Street School of Medicine and then at the College of Physicians and Surgeons in Crosby Street.

The importance of the study of the diseases of the skin was then realized. American students began to seek special instruction in this branch of medicine, and they went to Paris, where the Hôpital St. Louis offered the most attractive clinical material. The works of Alibert, Biett, Gibert, Cazenave, Schedel and Rayer had made the palmy days for French dermatology. This is the reason that the American works of those days bear the characteristics of French dermatology.

Books and pamphlets on dermatology begun to appear in great numbers, and were also in great demand. These included the works of Plumbe, "Practical Treatise on the Diseases of the Skin"; Colles on "Venereal Diseases"; Hunter's "Treatise on the Venereal Diseases, with Notes by James F. Palmer"; Ricord's "Practical Treatise on Venereal Diseases," translated from the French by H. P. Drummond; Erasmus Wilson's famous "Practical and Theoretical Treatise on Diseases of the Skin." Rayer's "Theoretical and Practical Treatise on the Diseases of the Skin with Colored Plates," edited by John Bell. Rayer was one of the most prominent dermatologists of France, and his works have remained always conspicuous in dermatology.

In the year 1845, N. Worchester, professor in the Medical College of Ohio, published the first American work on diseases of the skin, "A Synopsis of the Symptoms, Diagnosis and Treatment of the More Common and Important Diseases of the Skin," with sixty colored plates; Philadelphia, Boston, Cincinnati. The author did not aspire to originality; in his preface he claimed his object to be utility. Dr. Noah Worchester was born in Thorton, New Hampshire, in 1812, and graduated at Harvard in 1832. He taught at the Dartmouth Medical College. He spent some time in the hospitals of Paris, where he acquired knowledge in skin diseases. On his return he located in Cincinnati and occupied the chair of general pathology in the Medical College of Ohio. Later he removed to Cleveland to occupy the same chair in the Medical School of Cleveland. He died at the age of 35, in Cincinnati.

The classic work of Prof. George B. Wood, "Practice of Medicine," has excellent chapters on diseases of the skin, to which students of the subject have turned for information.

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5. Jüttner: Daniel Drake and his Followers, p. 214.

Eruptive fevers had been well treated by Dr. Nathaniel Chapman, and the subject of erysipelas, which was epidemic, had been well studied by Gross. The question of the origin of puerperal fever and epidemic erysipelas was then very ably discussed by Thomas C. Minor[6] of Cincinnati.

In 1850 the University of Pennsylvania came into possession of a fine collection of models of skin diseases purchased by Prof. George B. Wood; these were wax models executed by the English artist, Joseph Towne. The models are reproductions of the best specimens in Guy's Hospital Museum. This collection was later enriched by the contribution of Dr. H. H. Smith, professor of surgery, with seventy models of cutaneous and syphilitic diseases.

Republications of foreign books, with notes by the American editors, marks the progress of dermatology in the period of 1846. Yet some contributions of value on dermatologic subjects appeared in the medical journals. Dr. Savage and Dr. Hutchinson reported changes of color in the negro. Dugas reported a case of glanders in the human subject. Valentine Mott of New York described five cases of dermatolysis or pachydermatocele.

The profession was looking toward a higher development of medicine; dispensaries and clinics were opened for cutaneous diseases in all large cities. There was the Northwestern Dispensary with Drs. H. D. Bulkley, J. L. Smith and Stephen Smith; the Howard Hospital in Philadelphia, with a special department for skin diseases in charge of Dr. Oliver H. Partridge. In 1856 a clinic for skin and venereal diseases was opened at the Eastern Dispensary of New York, with Drs. Morse and Belden; the German Dispensary of New York, in charge of Drs. Edward Schandler and Joseph Goldmark; in 1862 the Northeastern Dispensary of New York offered a similar service with Drs. J. Scott Payne and Thomas Haigh acting as alternating physicians.

Well qualified students were coming back from their sojourn in Paris, having acquired knowledge and practice in the field of dermatology in the celebrated Hôpital St. Louis and began to take positions as instructors and lecturers in this branch of medicine. It was at this time that the fame of the Viennese dermatologist, Ferdinand Hebra, was reaching this country, and well prepared young men went to Vienna to listen to the words of a teacher who could readily explain diseases which had been considered of an obscure nature.

Dr. James C. White was one of the first pupils of Hebra, and after some years of study under that eminent teacher, came back home, fascinated with his dermatologic studies. He wrote on epizoa, epiphytes and itch, on lupus vulgaris, nature of favus, psoriasis, etc.,

6. Minor, Thomas C.: Erysipelas and Childbed Fever. Cincinnati, 1874.

showing the force and value of the observations he made in the clinics of Vienna. In 1861 Dr. White gave his first course of lectures in Harvard University. In 1862 Dr. J. Adams Allen gave instruction in dermatology in Rush Medical College. At this period the war of secession broke out, and the attention of the profession was diverted to surgery, to save life and limbs, rather than to the refinements of medicine.

After the close of the war, important clinical lectureships on diseases of the skin were established; the first in 1865 in the University of New York, with Dr. F. D. Weisse head of the clinic, and later on, professor. When he resigned in 1874, Dr. Henry G. Piffard was elected to fill the vacancy. In 1866 Dr. William H. Draper lectured on diseases of the skin in the College of Physicians and Surgeons of New York; the following year he was appointed clinical professor.

In Bellevue Hospital Medical College in 1866 Dr. Foster Swift was appointed lecturer on dermatology, which office was afterwards changed to professor. After the death of Dr. Swift, Dr. Edward L. Keyes was chosen lecturer and then professor of dermatology.

In Philadelphia a chair on cutaneous and venereal diseases was established in Jefferson Medical College; Dr. Francis F. Maury was appointed to the position. He taught the subject clinically and theoretically, and as he was a distinguished surgeon, rendered the subject in an exceedingly interesting manner.

Piffard translated an essay of Hardy, "The Dartrous Diathesis, or Eczema and its Allied Affections." This work expounded plainly the views of the French School on the topic of cutaneous diseases, renewing the views and the doctrines of diatheses in skin diseases, following the treatise of Hardy and Bazin. At the same time the book of Hebra was published in English by the New Sydenham Society. His views, clear and simple, based on his large experience and on the pathologic doctrines of Rokitanski and Skoda, were immediately accepted by the great majority of dermatologists. The simplified nomenclature, the classification of the diseases of the skin, the well adapted therapeutic applications, made dermatology accessible and understood to all students.

At this period the science of dermatology had already advanced in the European cities, and it was the subject of serious study in this country. The works of Howard F. Damon, Edward Wigglesworth, L. A. Duhring, Henry G. Piffard, James C. White, Geo. T. Jackson and many others, established a solid base on which American dermatology is building its monument. It was in 1869 that the Dermatological Society was organized in New York. Its object was well defined to afford all those interested in this important department of medicine

an opportunity for a free exchange of their opinions and methods of practice, and to contribute American experience and investigation to the fast accumulating stock of knowledge of the diseases of the skin. This organization has since exerted a marked and unquestionably beneficial influence on the profession.

All this was promising for the individual members of the profession, but yet, as Dr. Keyes[7] wrote, the necessity of an American journal of cutaneous medicine was keenly felt. Indeed, journals of dermatology in Italian, English, German and French were published, but none on this side of the water. In 1870 appeared the *American Journal of Dermatology,* under the editorial management of Dr. M. H. Henry of New York, which constituted an event of import to American dermatology. It began to bring forth a considerable amount of facts and observations in this branch of medicine and was able to obtain an honorable position abroad as well as at home. This journal was discontinued and was followed by the *Archives of Dermatology,* under the editorial management of L. D. Bulkley, in October, 1874, continuing until October, 1882. At this time Drs. H. G. Piffard and P. A. Morrow issued the first number of the Journal of Cutaneous and Venereal Diseases, which continued under the joint editorship until 1886, when Dr. Piffard retired, Dr. Morrow continuing as The Journal's sole editor. Dr. Fordyce, in 1889, became associate editor, and in 1892 was the sole editor. In 1896, Johnston coöperated with Fordyce until the latter retired from the editorship, The Journal continuing under the editorship of Johnston and Swinburne, with six associate members.

The Journal had the title of *Cutaneous and Venereal Diseases* until 1886. In 1887, venereal was dropped and the title was continued for many years as the *Journal of Cutaneous and Genito-Urinary Diseases.* In December, 1902, a change of hands in the administration of The Journal was announced. It was recognized that a line of separation was necessary between dermatology and genito-urinary diseases, both grown to the point of being regarded as separate specialties. In January, 1903, it appeared as The Journal of Cutaneous Diseases, Including Syphilis. The object was to have a medium for presenting the subjects of dermatology and syphilology alone. It was under the editorial direction of Drs. White, Hyde, Bronson, Morrow, Stelwagon, Jackson, Bowen and Fordyce, with Mewborn of New York as acting editor.

The Journal has always published original papers and exhaustive epitomes of practical character relating to the progress of dermatology in all parts of the world. It had been and it is the official channel of

7. Keyes: New York Med. Jour., June, 1869.

publication of the transactions of our Association, and the reports of the several dermatological societies in different cities. In these last years it has become the property of this Association, and under the present editorial staff, which deserves the support and the gratitude of every member of the Association, has reached the point of being one of the best journals of this kind for scientific communications, research work, clinical and microscopic illustrations, etc.

THE JOURNAL has to gain more circulation and be more appreciated among the general practitioners, who no longer have an excuse for their ignorance of skin diseases. The publication is continuously gaining in favor among foreign dermatologists, and the works of American dermatologists are widely quoted in Europe. Indeed, as Dr. White said, medicine is to advance to its highest development by the united labors of all nations, and any school is sadly narrowed which ignores the works of others.

We can say with Dr. George Thomas Jackson, that the record of the past is one of which we may well be proud. With the passing years we have grown stronger and stronger. We are a harmonious body, working for the honor of our Association and the work is of the highest grade.

History contains the elements of evolution, as well as of revolution. A link of mutual responsibility joins us as in one family, as a perfect chain of causation unites all changes. In the present status of the science we must not believe all we have heard, nor must we believe in statements made by old writers, without proof; we must believe only in what rests on reliable observation and analysis, and agrees with facts based on scientific truths. Facts, even when rightly observed, are not truths, they only yield them. As Roger Bacon said, "Truth is shaped, molded, evolved by the conjoint working of reason and fact." The first step is observation, then experiment comes to test and prove the observation, that it may become knowledge.

It is possible to construct a system of a pseudoscientific nature dealing with supposedly similar diseases, and various remedial agencies, out of whole cloth; but it will hardly bear the test of methodical investigation. Inquiry is the highest and noblest exercise of the intellectual faculties. It is a fact that in many scientific and philosophical questions, early thinkers have given currency to errors, which it has been the duty of the after-comers to revise and correct.

Very appropriately, Dr. Fordyce,[8] in his chairman's address, pointed out the complications of our nomenclature as a handicap to the students in imparting correct ideas on the nature of cutaneous

8. Fordyce: Address by the President of the Amer. Dermat. Assn. Twenty-Third Annual Meeting, Philadelphia, 1899.

affections. Moreover, the great importance attached to trifling modifications in the character, grouping and distribution of lesions, in many cases makes for neglect of more important features, which certain classes of diseases have in common. In the group of inflammatory diseases, some erythemata, urticarial eruptions, dermatitis herpetiformis, pemphigus and even purpura show some common manifestations, which very likely depend on similar toxic agents acting on the vasomotor apparatus in individuals with different degrees of susceptibility. In the same way toxic agents proceeding from the same origin differ in their virulence, modified in their action by the resistance of the organism or by a partially acquired immunity of the individual.

Micro-organisms may produce toxic elements of different degrees of toxicity, according to the conditions in which they are placed. It is known that the tubercle bacillus in the skin gives toxic products less virulent than those in the lungs or in the joints. The origin of the bacilli has also great influence. The bovine tubercle bacilli are much more virulent, and this explains the difference of the clinical characters and of the course in a progressing lupus. Pyogenic organisms also show great difference in their virulence according to their source, to their quality, and to the condition of the system of the affected individual, thus explaining the differences in the appearance of the same disease.

Pathologic and bacteriologic investigations have enlightened many obscure points on the etiology of many diseases of the skin, and it is presumable that other affections, not yet well defined, like granuloma fungoides, will soon be cleared up.

Recent investigations have revealed the influence of disturbed internal secretions on the production of cutaneous affections. From the first productions of Brown-Séquard, in 1889, to the latest works of Biedl,[9] Poor,[10] Bayliss[11] and Starling,[12] concerning the hormones and the endocrine organs, light has been thrown on some obscure diseases and our views have been changed. It has been shown that every cell of the organism undergoing biochemical changes, by its own secretory products mixed in the stream of the circulating blood, is capable of producing a certain influence on the whole, by chemical correlation. All those organs which are producing hormones are to be considered as organs of internal secretions or endocrine organs. The internal secretions, either in an increased or in a diminished quantity, or perverted in quality, produce toxic elements, which poison the sys-

9. Biedl: Innere Sekretion. Berlin, 1913.
10. Poor, Franz: Ueber die Beziehungen einiger Hautkrankheiten zu der inneren Sekretion.
11. Bayliss: Naturforscher Versammlg., Stuttgart, 1906.
12. Starling: *Ibidem.*

tem. The other secretory organs usually compensate the activity of the perverted one so as to render the secretion less injurious to the system. Morbus Basedow is often accompanied by skin lesions as are also myxedema, acromegaly, dystrophia adiposa-genitalis, resulting from disturbances of these glands. Some pigment anomalies are the direct results of diseases of the suprarenal glands. The study and the progress of this scientific subject promises to reveal the nature and the origin of many other obscure diseases.

Some changes are taking place in the therapeutic field, which have a tendency to alter all our views in the old canonical treatment of the cutaneous affections. Vaccines and serum therapy, autoserum, the endovenous infusions with different remedial agents are already changing our methods of treatment.

Now we can apply here what was said by LeConte: "Stability is never perfect, the point of equibrium is ever moving, disturbed equilibrium is soon readjusted on higher plane with still more beautiful and complex interrelations." Permanent equilibrium in any institution or society means social stagnation and decay. We have seen this Society in its onward movement, and it has to continue on its way of progress.

The limited number of members keeps this Society up to the highest standard. A dermatologist, when received into this Association, well knows that he has received the highest recognition from his colleagues. Indeed, as Voltaire[13] said, "the highest triumph of human pride is to receive titles of honor from those who think themselves our equals." It is difficult to arrive at this point in any monarchical government, but in our democratic America we have clearly succeeded. For this reason, a man who is dedicating his life, his work, his efforts to the study of dermatology, will feel, when elected a member of this Association, that he has received the highest honor from his colleagues.

From the standpoint of humanity the world knows how serious and unselfish have been the endeavors of medicine to prevent disease, to promulgate the science of sanitation and to further the cause of higher medical education. The dermatologist finds a wide field to work in, to prevent spreading of contagious diseases among the people and especially among the children in the schools.

The teaching of dermatology in the medical schools should be incumbent on the Association. The ability of the teachers, the time given to the clinics, the number of cases treated, ought to be known to the Association. It would be desirable that the Association enter into relations with the medical licensing boards, and see that a number of questions in dermatology and syphilology be given to the applicants as a part of the final examinations.

13. Voltaire: Essays on Literature, Philosophy, Art, History, 37, p. 209.

I mentioned syphilology because this special branch of medicine has to be a part of dermatology, and the dermatologist only has the ability and the right to teach the general principles of this disease. In reference to the teaching of syphilology, Zeisler[14] sounded a strong note last year when he read a paper on "The Dermatologist the Proper Teacher of Syphilis." The same ideas were upheld by Irvine[14] and by Hazen,[16] pointing out the necessity of a better teaching of syphilis, and that the dermatologist is the proper man to head this department. The discovery of the spirochæta, the seroreaction, the treatment by arsenobenzol, has rendered the subject of syphilis more accessible to other workers in other departments of medicine, and also to the general practitioners. Yet every one of us finds in his experience cases of ulcerated gumma treated for cancer, cases of circinate syphilis treated for lichen, for the only reason that the Wassermann test was negative. The general teaching of syphilis, its history, general pathology, histology, serology and treatment should remain with the dermatologist. The inception of syphilis is in the skin, the further manifestations are in the skin and mucous membranes; an early diagnosis with an appropriate treatment will save the patient from unfortunate complications and from sad consequences. The early recognition of the specific origin of an ulcerated tumor will save the patient from an unnecessary and useless surgical operation.

Syphilis, a preventable disease, must be stamped out, and the responsibility lies mostly on the dermatologist. Syphilis is crowding hospitals and asylums with wrecks of humanity, causing an incalculable expenditure of the public money; it must be prevented by all the means at our disposition.

The study of dermatology is not exactly limited to the skin; it explains the pathologic processes occurring in the internal organs, and for this reason is one of the most important branches of the medical sciences. In order to explain the manifestations on the skin of bullous eruptions, ulcers, gangrenous spots resulting from neuritis or from vasomotor disturbances a knowledge of neurology is necessary. It requires a full knowledge of the toxic elements which are produced in a dilated stomach in a sluggish condition of the intestines. Rosacea, acne, pustular eruptions, stubborn cases of eczema, etc., often owe their origin to an intoxication from the *Bacillus coli communis*.

The dermatologist has to be also a surgeon, and I believe that we should claim many operations which are usually referred to the gen-

14. Zeisler, J.: The Dermatologist the Proper Teacher of Syphilis. Jour. Cutan. Dis., August, 1916, 34, p. 582.

15. Irvine, H. G.: Notes on the Teaching and Treatment of Syphilis. Jour. A. M. A., Dec. 30, 1916, p. 1987.

16. Hazen, H. H.: The Teaching of Syphilis. Am. Jour. Syph., 1, p. 135.

eral surgical department. Skin grafting, the transplantation of the skin, plastic operations and many other operations ought to be performed by the dermatologist, who thoroughly knows the anatomy, the physiology and the properties of the skin, as well as the necessity and time for operating. In erysipelas, abscesses of an infectious nature are often formed, which must be opened soon and drained in order to prevent general streptococcic infection, and to stop the wandering of the erysipelas. In some cases of phlegmon of the hands, feet, legs and face, the only way to stop the infection is by the prompt use of the knife and by good draining. In the treatment of leg ulcers from varicosities, ligation of the dilated veins, or the stripping of the internal saphena must be done in order to obtain healing of the ulcers.

I may say that even in the treatment of acne, if the pustules are not opened and the contents removed, we cannot obtain satisfactory results. Cases of local pruritus are today treated surgically. Cancer of the breast, cancer of the penis, Paget's disease ought to be given to the dermatologic department for treatment. The genito-urinary men, who have some points in common with our specialty, have today taken charge of every disease from the penis to the kidney. I do not see any reason why we have to acquiesce and let the surgical department take charge of our cases and operate on them. I believe that it is time that a surgical department of dermatology be instituted in the American College of Surgeons.

It should be the duty of our Association to see that the medical colleges offer to the students special pathologic instruction connected with the dermatologic department. The students should know the principal histologic alterations which take place in the skin, in the different diseases. They ought to be trained to prepare the skin for biopsy, cut it in sections and stain according to the different elements to be examined. In the same way, they must be able to examine the scales and crusts for the fungi which infest the skin. They should have some instruction in the cultivation of the different elements on culture media. In such simple affections as scabies, they must recognize the acarus, be able to take it out from a furrow and prove the existence of the itch mite.

The statistical reports of cutaneous diseases should be continued, and Dr. Pollitzer is to be congratulated for his very valuable statistical compilations.

At the present moment of acute crisis for our beloved country, our President, with his keen intuition and firmness, is able to inculcate in our people principles of superior wisdom, of liberty and democracy; and as a worthy chief in a commonwealth of freemen, resenting the affront to the United States, rather than submit to humiliation, has

declared that a state of war exists between the United States and the German Empire. At this delicate moment the American Dermatological Association has been requested by the Committee for National Defense to appoint a committee to confer with the medical advisers, and report on the activities of its members. Drs. Pusey, Fordyce and White were appointed and they have already responded, and have suggested the rôle that the members should play in the treatment of diseases with which they are most familiar.

Our Association is constantly progressing on a solid scientific base; every meeting is a new addition to its structure. Every year we meet each other, we communicate our ideas to each other; every meeting is a scientific and a social celebration. In going back home we carry with us new knowledges, new ideas, new views, new hopes, which we will develop for the good of science and for the benefit of humanity.

I will close my remarks with the verses of Roger Bacon:

> . . . and when the stream
> Which overflow'd the mind has pass'd away,
> A consciousness remains that it has left
> Deposited upon the silent shore
> Of memory images and precious thoughts.

Original Communications

A CASE OF MULTIPLE BENIGN TUMOR-LIKE NEW GROWTHS OF SCHWENINGER AND BUZZI *

WILLIAM ALLEN PUSEY, M.D.
CHICAGO

Schweninger and Buzzi[1] described, under the name Multiple Benign Tumor-Like New Growths, a case showing a unique anomaly of the skin.

Crocker[2] says that cases have been also "observed" by Malcolm Morris, Colcott Fox and Van Hoorn, but gives no reference to any publication of these cases. He also refers very briefly to another case: "I have seen very similar lesions associated with fibromata of the ordinary form, when some of them have been absorbed."

Stelwagon[3] refers to a case which he has met, "in a middle-aged woman, with thirty to forty such bladder-like tumors over the region of the right shoulder, and immediately adjacent part of the back; they were of extremely slow development, and, as in the other cases, gave rise to no subjective symptoms. Over the well developed and older tumors the integument was distinctly atrophic or cicatricial looking, but soft and elastic."

I should say that Stelwagon's brief description represents a case of the condition, but Crocker's description of bladder-like soft tumors occurring in multiple fibroma, which are familiar, makes me doubt very much if his description refers to one of these cases.

So far as I am able to find, without pretending to have made an exhaustive search of the literature, there are no other cases of this peculiar condition described in dermatologic literature. In fact, there is only one completely recorded case—the original case of Schweninger and Buzzi. I wish to report another case which strikingly corresponds to the one described by Schweninger and Buzzi.

REPORT OF CASE

C. E., a man, aged 37 years, consulted me in regard to a peculiar permanent condition of the skin; more for the purpose of ascertaining its character than with the hope of finding out if anything could be done for it. The con-

* Received for publication June 4, 1917.
* Read before the Twenty-Fourth Annual Meeting of the American Dermatological Association, Cincinnati, May 24-26, 1917.

1. Schweninger and Buzzi: International Atlas of Rare Skin Diseases. 1891 Part 5, Plate 15.
2. Crocker: Diseases of the Skin. Third Edition, p. 702.
3. Stelwagon: Diseases of the Skin. Seventh Edition, p. 667.

dition was characterized by small, almost flat, scar-like spots and oval swellings from the size of a pinhead to that of a hazel nut.

These lesions were found on the face—particularly the chin—on the upper half of the arms, on the back and buttocks. They varied from slightly elevated, small spots to hemispherical, bulging swellings, which looked as though at these points there was loss of strength in the skin so that it yielded to the pressure beneath. The lesions on the chin are well shown in the accompanying photograph. These, as well as the lesions elsewhere, are much more distinct by side light than by direct light. A side light is necessary in order to see the smaller lesions clearly. The term "tumor-like" of Schweninger and Buzzi is a happy description of the larger lesions. They are raised, oval or hemispherical tumors, but they are as soft or softer than the normal skin, and are completely reduced either by light pressure over them or by putting the skin on the stretch. When the pressure is removed they immediately resume their original shape. The patient's barber had noted that the masses flattened out under the razor, and that there was no difficulty in shaving over them. The skin over the lesions on the chin is of normal color or occasionally shows a faint slate color or reddish tinge. In the larger lesions some dilated blood vessels are visible. The hair follicles show no visible change. These lesions on the chin are the largest that exist except those on the buttocks.

The lesions on the upper lip are few and of the same appearance as the smaller lesions on the chin. Numerous very slightly elevated lesions are found on the forehead. On the face, as elsewhere on the body, the eruption is evenly distributed on the two sides.

On the back the lesions occur in an area extending at the midline from the third dorsal to the second lumbar vertebra, and from the posterior axillary folds to the crests of the ilia. The lesions here are not globular, but are oval or linear patches, very slightly raised above the level of the surrounding skin, and look like thin scars or slightly raised blisters. Many of them are visible only by side light. In size they may vary from a pinhead to that of a fingernail, and they are arranged with their long axis following the cleavage lines of the skin. Some of them are distinctly whiter than the normal skin; they look, in fact, like the white scars that result when bits of skin are clipped out to make skin grafts. Other lesions, particularly the larger ones, are of a light yellowish brown color. In the larger lesions the surface has a cigaret paper appearance, and the fine markings of the skin are accentuated. Some of the lesions show a few dilated follicles on their surface, but none of these follicles appeared as blackish points, as described by Schweninger and Buzzi in their case.

The lesions on the arms are similar to those on the back, and are confined to the extensor surfaces of the upper half of the arms. There are no lesions on the forearms or hands.

On the buttocks the lesions are very numerous, and are largest, some of them having a long diameter of about 2 cm.

At the sides of the neck, back of the ears, the skin is mottled by small oval spots, 4 mm. in long diameter which are slightly lighter in color than the surrounding skin. While their elevation cannot be made out—on account of the fact that they are covered with hair—there seems no reason to doubt that they are lesions of the same character as those existing elsewhere.

The lesions show no disturbance of sensation.

The lesions first appeared on the chin, and were discovered when the patient was about 22 years old—fifteen years ago. They were noticed on the back about three years later. They have slowly increased in number since. The patient thinks that the lesions attain their full size in a few months and subsequently do not enlarge. Many of the flattened lesions look as though they might have shrunken. On the other hand, the atrophic character of the lesions would account for this appearance, and as far as the patient has observed there has been no shrinking of the lesions. Their appearance and their subsequent course have been absolutely unassociated with subjective symptoms.

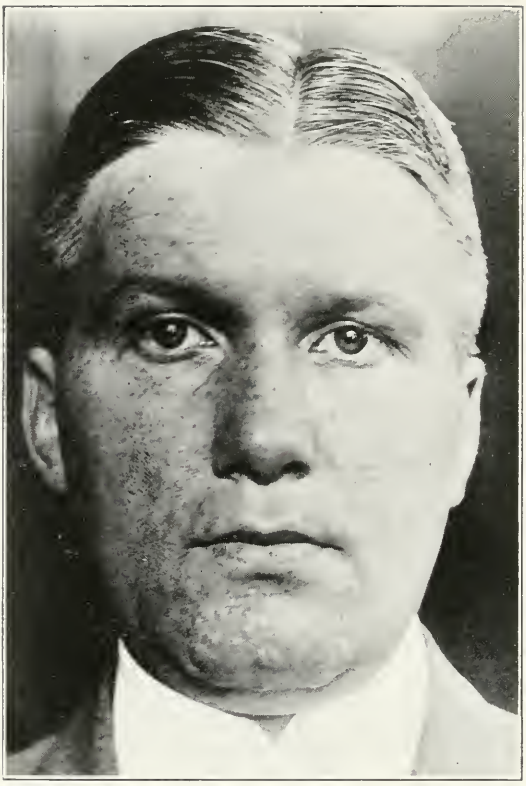

Fig. 1.—Showing multiple lesions on chin.

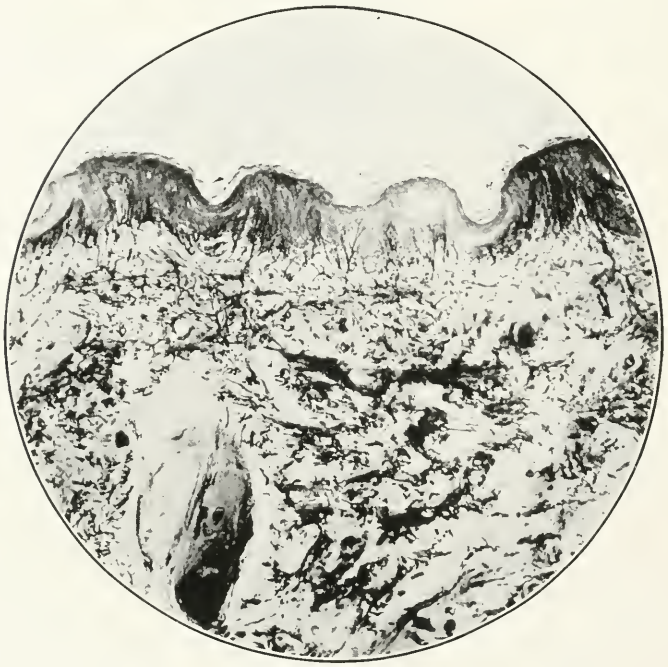

Fig. 2.—Showing elastic fibers in border of lesion. Weigert's stain.

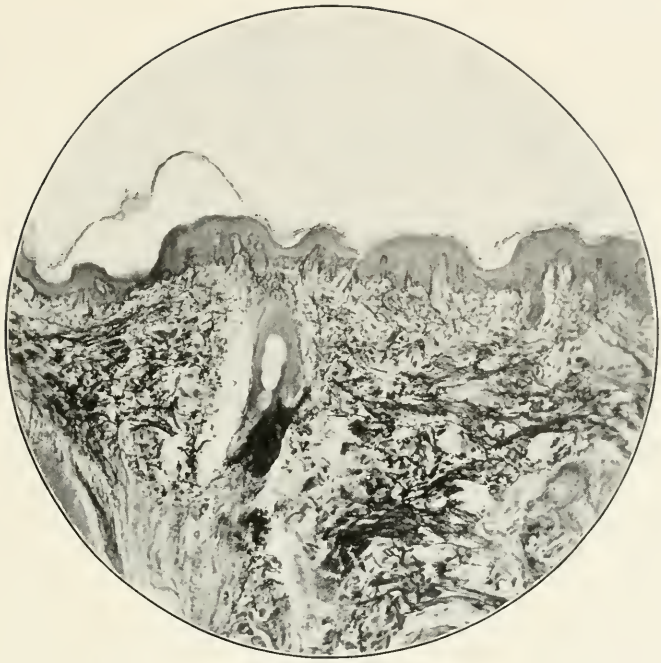

Fig. 3.—Showing elastic fibers in border of lesion. Weigert's stain.

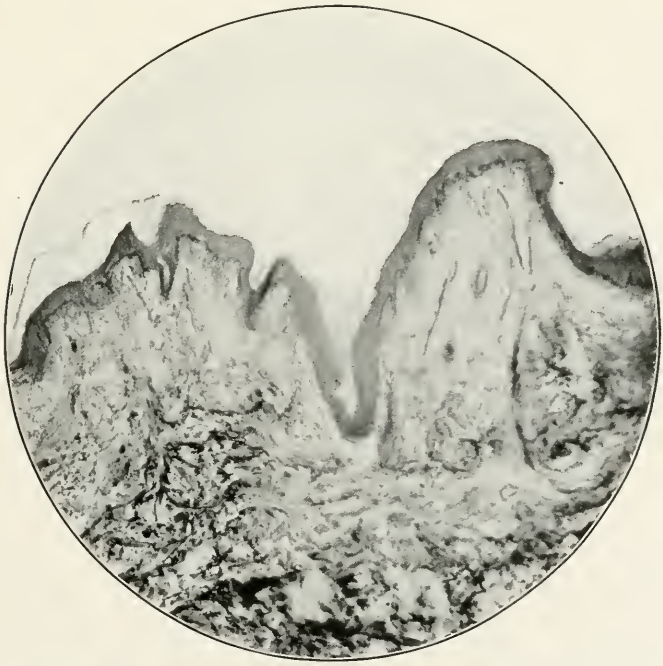

Fig. 4.—Absence of elastic fibers in center of lesion. Weigert's stain.

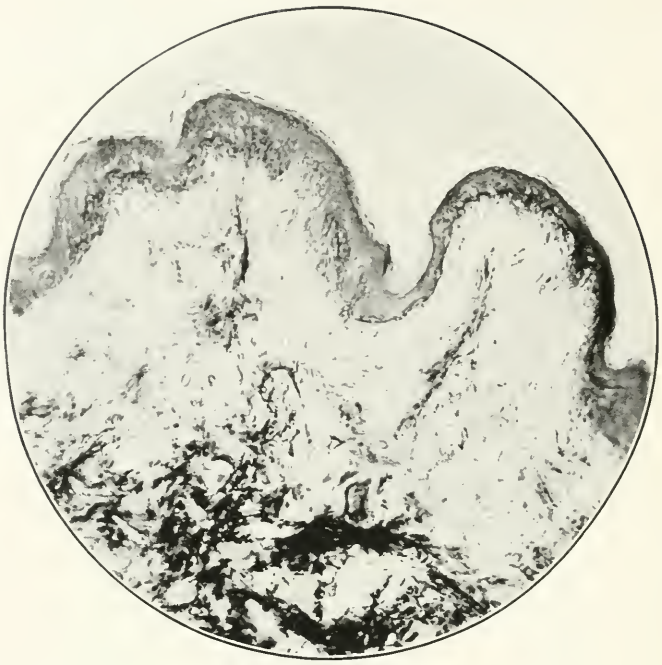

Fig. 5.—Absence of elastic fibers in center of tumor. Weigert's stain.

Fig. 6.—Multiple benign tumor-like new growth. Lesion under low power showing hernia-like projections in center of tumor. H. & G. stains.

The patient is an intelligent man of the upper class, of medium height and weight. Over the trunk there are a few small senile ectases and a few pigmented moles, but their number is not extraordinary. He has no other cutaneous defects. He is in vigorous health and has never had any serious illness. He has not had syphilis. As far as he knows there has been no similar condition in any other member of his family.

Histologic Report

One of the smaller but distinct lesions on the back was excised, fixed in liquor formaldehydi, embedded in paraffin, and stained with hematoxylin and eosin, polychrome methylene blue and orcein, and Weigert's stain. When the section is examined under a very low power, it is seen that near the center of the section the epidermis is raised above the level of the surrounding parts in several verrucous folds, and that the interpapillary processes are fewer in number and shorter. Under a higher power it is found that this portion corresponds exactly with the loss of elastica.

The stratum corneum shows no change. There is no parakeratosis. Traces of stratum lucidum are visible here and there. The granular layer is unaltered, varying in thickness from one to two layers, and the granules and nuclei of the cells appear normal. The rete malpighii shows no marked change, although it appears to be somewhat thinner in the affected part, and in some specimens the cells seem to be more closely packed. The basal layer is unchanged.

The corium is the seat of most interesting changes, the picture corresponding almost exactly with that previously described by Schweninger and Buzzi. The striking features are: first, a marked loss of elastic tissue in the involved area, and second, an infiltration of round cells about the blood vessels. The most marked change in the elastica is in the papillary and subpapillary portions. Differential stains show a complete loss of elastic tissue here. In the deeper layers of the corium there is also a considerable diminution in the number of elastic fibers, and those remaining are broken and fragmented. lesion. Beyond the border the elastica is normal. An increase in its amount at the border as described by Schweninger and Buzzi is not apparent in my sections. The part in which the most complete involvement has occurred is well demarked from the surrounding skin in two ways. First, by the fairly sharp beginning of the loss of elastica; and second, by the bulging outward of the epidermis: the latter is undoubtedly due to the fact that the skin, weakened by the absence of elastica, has yielded somewhat to the pressure beneath and been pushed out in a hernia-like swelling.

The cellular infiltrate occurs particularly and almost exclusively about the vessels. The infiltrate is confined for the most part to the vessels of the superficial layer of the cutis. It does not occur around the sweat and hair follicles, as in Schweninger and Buzzi's case. The cells of the infiltrate are, for the most part, of small round-cell type, although there is also a considerable increase above the normal in mast cells and plasma cells. There is a moderate dilatation of several of the larger subpapillary vessels. Aside from the loss of elastic tissue and the perivascular infiltration, the corium is normal. There is no change in the collagen. There is no enlargement of the sebaceous and sweat glands, and those present are of normal appearance.

COMMENT

There is little difference between this case and the case reported by Schweninger and Buzzi. In their case the disease appeared in a woman, at the age of 22, about six months after marriage. The distribution was almost the same. The lesions were found on the back and arms, and one on the chin. Their size, shape and distribution were the same. They were whitish, or normal in color; some of them with a slightly

blue tint. This bluish tint was lacking in my case except for a slaty color in the lesions on the chin. They disappeared under pressure and the swelling reappeared on its removal. There was no disturbance of sensation, and there were no subjective symptoms. The patient was a healthy woman with a healthy husband. There was no history of a similar condition in other members of the family.

The same changes were found in the elastica, and were found in all of their sections. They found around the blood vessels an accumulation of young round cells, which was especially marked in the superficial horizontal network. They found a similar infiltrate around the sebaceous glands, hair follicles, and tubes of the sweat glands. This infiltrate around the follicles of the skin was not found in my sections. They also found a proliferation of the endothelium of the blood vessels, and an enlargement of the sebaceous glands. These were absent in my sections.

Schweninger and Buzzi regarded the condition as a pathologic process characterized by degeneration of the elastica. The whole picture strikes me as a congenital defect in the skin — one characterized by failure of development of the elastic fibers in minute areas of the skin; this lack of elastic fibers in the upper part of the corium resulting in a weakening of the corium and a consequent bulging in these areas. The appearance of the lesions only in adult life might readily be accounted for by the fact that the weakness in the structure of the skin might not be sufficient to cause it to manifest itself in the youthful skin, but would show itself by yielding at the points of defective structure as the skin lost its youthful tone. The slight cellular infiltration in the skin might be accounted for by the injury to the tissues which resulted from their giving way. A similar infiltration may be found in linea albicantes, which are in a way, analogous lesions. A congenital defect of development of elastic fibers is not an unknown occurrence. Engman and Mook have shown that there is a congenital lack of development of elastic fibers in the papillary layer in epidermolysis bullosa.

DISCUSSION

DR. HARTZELL said he had not had the opportunity of seeing these photographs, but the clinical description was very much like some of the lesions of fibroma. He should like to ask the reader of the paper if that was at all the impression from a superficial examination.

DR. PUSEY replied, Not at all. He thought of soft fibroma in connection with it.

DR. ENGMAN said he would like to ask Dr. Pusey if there was a loss of elastic tissue due to certain inflammatory changes or to a degeneration.

DR. POLLITZER said it was interesting to note the difference that we got in the various conditions of the skin in the absence of elastic fibers or degeneration. It would be of value, he thought, if Dr. Pusey or those who have had opportunity to study the conditions, would devote special attention to an explanation of the clinical differences in appearance we found in these conditions. Why in one case there was the congenital absence of elastic fibers, as

in epidermolysis bullosa, and in other cases we got simply soft, tumor-like masses. In some cases we had a pronounced degeneration of elastic fibers with fragmentation of the fibers, as in pseudoxanthoma elasticum. We had a yellowish pigmentation, we had tumor-like growths that had a distinct yellowish appearance. He should like to ask Dr. Pusey to illuminate this phase of the subject.

Dr. Engman said that in the case of amebic infection he was going to report this morning, like all cases, when the ameba entered the skin it had a specific and dissolving effect on the elastic tissue at once.

Dr. MacKee: There was another group of cases which, perhaps, would have to be considered in differentiation. There was a case of dermatolysis of the papulo-nodular type reported by Dr. Wise several years ago. One of the marked features in the lesion histologically was the absence of elastic tissue. Clinically the lesions did not look unlike the clinical picture presented by Dr. Pusey. Another striking histological feature was the myxedematous degeneration of the connective tissue.

Dr. Pusey said that the case he reported was the second one on record, and no generalization should be made from two cases. It was rather too early to make a generalization. He did not know where the case belonged except in the group of Schweniger and Buzzi, which was practically identical. He thought of the possibility of multiple fibromyomata and the necessity for differentiating it. Clinically it presented no more resemblance to the usual case of multiple fibroma than to lupus erythematosus. The picture was one of slight bulging of the skin with no new growths as had been mentioned, and clinically the case presented no similarity to multiple fibromyomata. Histologically also, it was not multiple fibromyomata. There was no question in his mind but that it was a congenital defect in the skin, and to that extent it was probably analogous to multiple fibromyomata.

As to the point raised by Dr. Engman of whether there was inflammatory degeneration, the inflammatory factor was a distinctly secondary one; it was only around the vessels, and examination of the sections did not give the impression that it was elastic tissue degeneration following inflammation, but that the inflammatory change was purely of a secondary character. Schweniger and Buzzi explained it as being due to inflammatory degeneration. He did not think they were correct. There was no evidence of any such microscopic phenomena yet. He compared the case with Dr. Wise's case of dermatolysis, and he concluded from that comparison that the two conditions were entirely distinct and not analogous. It was practically a unique case.

Dr. Heimann said he would like to know what Dr. Pusey's views were on the relationship of this condition to macular atrophies. Clinically and histologically there were a great many points of resemblance.

Dr. Pusey asked what the last speaker meant by macular atrophy?

Dr. Heimann replied, Small, tumor-like, slightly elevated masses developing in these cases, which led subsequently to a localized atrophy.

Dr. Pusey said he did not have a clear picture in mind and could not answer the question.

Dr. Pollitzer brought up an interesting question. We had one congenital defect of the skin with circumscribed areas of loss of elasticum, in which we had lesions like these. We had epidermolysis bullosa with loss of elastic tissue, with an entirely different clinical result. There was one distinction, and that was in epidermolysis bullosa in most cases the loss of elasticum had been universal, while in this case it was not confined to the affected areas. Why loss of elastic tissue did not cause epidermolysis bullosa in these cases he did not know. It may be there were some fibers existing in the superficial layer, and the members may have thought he was alluding to that, but he was not.

Dr. Pollitzer inquired if the elasticum around the blood vessels was preserved.

Dr. Pusey replied that in the affected areas the elasticum was preserved. The blood vessels showed no difference from the rest of the area.

THE ELECTRIC CAUTERY IN CUTANEOUS SURGERY*

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We frequently hear it stated that dermatologists are mere purveyors of salves and lotions, and that they do not pay enough attention to either the general physical condition of the patient or to the proper surgical treatment of infections or of conditions demanding surgical removal. An examination of the modern textbooks on dermatology should serve to dispel, to some extent at least, both of these opinions. And yet none of the books makes more than casual mention of the use of the cautery in cutaneous surgery, although all surgeons know that this instrument is extremely valuable in certain conditions.

There are many skin lesions that demand removal; in this list may be included corns, callosities, granuloma pyogenicum, dermatitis vegetans, lupus vulgaris, blastomycosis, molluscum contagiosum, venereal warts, xanthelasma, keratoses, cutaneous horns, benign fibro-epitheliomata or papillomata, pigmented nevi, various types of angiomata and lymphangiomata, benign tumors of the cutaneous appendages, cancers, sarcomas, keloids, various benign tumors and leukoplakia, where the removal of local irritation will not suffice. Lastly, it is frequently necessary to remove a small portion of tissue for diagnosis, especially to determine whether or not malignancy exists.

To remove such growths we have at our disposal a number of methods. There are the various caustics, such as arsenic, zinc chlorid, trichloracetic acid, the acid nitrate of mercury and caustic potash. Carbon dioxid snow probably should be classified in this group. Among the electric methods there are fulguration, diathermy, etc., also the electric needle. The Roentgen ray and radium are used in some conditions, and lastly there remain the curet, the knife and the cautery, either Paquelin or electric.

The caustics have certain marked disadvantages: the superficially acting ones, such as silver nitrate, are worthless except in some extremely superficial lesions, and the ones that act deeply are extremely difficult to control, especially as they must act over a considerable space

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of time. The pain is usually very intense; any patient who has had an arsenic paste employed for cancer is not anxious to repeat the experience, unless he enjoy martyrdom. Finally, the employment of such remedies does not permit of histologic examination of the removed tissue, a point which is always important if one is to practice medicine scientifically. Carbon dioxid snow obviates some of these disadvantages, for it is quick and usually not painful, but as a rule it does not act sufficiently deep. In cancer or lupus vulgaris it is valueless or worse than valueless, for many has been the case of cutaneous cancer that has simply been stimulated by it. Bloodgood has shown that even when ordinary moles are treated with it, some of the nevoid cells are apt to remain. However, in the treatment of certain of the angiomas and of lupus erythematosus, it is extremely valuable. From considerable personal observation the author does not believe that fulguration and diathermy present any value that the cautery cannot equal, and in addition they are much slower in their action. The electric needle is of value in removing small, superficial, nonmalignant conditions, for it is painless and leaves an excellent cosmetic result, but it is entirely too slow for large lesions.

The field of the Roentgen ray and of radium is small, although at times they are of extreme value in handling cases of cancer, sarcoma, lupus vulgaris, blastomycosis, keloids, keratoses and many of the inflammatory skin diseases. They will remove practically none of the other conditions mentioned in the foregoing list, unless their action be carried to the point of producing a burn, and it is fortunately not necessary to dilate on the danger of either radium or Roentgen ray burns.

The use of the curet alone is always to be deplored, inasmuch as it leaves an ugly, jagged wound, and inasmuch as it cannot touch the outlying pathologic cells that are usually to be found in otherwise normal tissue. When followed up by a caustic, as the acid nitrate of mercury, it may be valuable in various superficial conditions, such as basal celled cancer. The use of the knife is unquestionably the cleanest way of disposing of many lesions, particularly of the nonmalignant neoplasms; in the hands of a really competent surgeon the resulting scar is often almost infinitesimal. However, the operation must be surgically clean, the wound must be closed with stitches, and dressings are always required, as well as more or less after-care. A fairly wide margin must always be available. The knife gives the best tissue for pathologic examination.

For heavy work the actual cautery is probably superior to most of the electric cauteries, for the blade will not burn out so readily, when removed from the tissues; but for light work the electric cautery has

several great advantages: it is mechanically easier to operate, and it is easier to keep at a steady heat, either dull red or bright red. With the cautery one simply cannot do a dirty operation; scrubbing and sterilization of the hands, of the instruments and of the patient can safely be dispensed with. An operation can be done with great rapidity, and with the use of a local anesthetic is painless. After operation the wound is perfectly dry and there is no occasion for hemostasis, no dressings are required, for the scab makes its own dressing. Where it is impossible to give much margin, the cautery is the ideal instrument. In cases of malignancy the blood vessels and lymphatics are sealed and all of the neighboring cells are thoroughly cooked; all surgeons are agreed that in malignancy there are fewer recurrences after the use of the cautery than after the use of the knife. And finally, the cosmetic results are excellent, for the resulting scar is comparatively small and is white, soft and flexible. Tissues are available for microscopic examination, although the edges are completely spoiled.

In my own work I have found the electric cautery to be of the greatest value in the treatment of the following conditions: soft corns, granuloma pyogenicum, lupus vulgaris, keratoses, papillomas, pigmented moles, xanthelasma, cancer, leukoplakia and for the removal of tissue for diagnostic purposes, where malignancy is suspected. In soft corns there is probably a lymph vessel that aids in supplying fluid to the lesion and keeping it soft, and if this be sealed with the cautery the lesion will permanently disappear. It has been our custom to excise the lesion with a fairly heavy blade and then thoroughly cauterize the base. In granuloma pyogenicum the protruding mass may be excised and the base simply touched. In lupus vulgaris deep cauterization is necessary, for the lesions have a most unfortunate way of recurring after any superficial type of work, a tendency that can readily be explained by a study of the pathology of the condition, which is deeper than the average physician realizes. In the case of keratoses, the edge of the blade is inserted at the edge of the lesion and then shoved along beneath it; papillomas may safely be treated in the same way. Pigmented moles are simply touched with the point of a small blade; we have removed lesions from the eyelid with perfect cosmetic results. Malignant conditions should be excised as is done with a knife. In leukoplakia, the flat of the blade is simply applied to the lesion. In all cases local anesthesia is employed, just as though a knife were to be used.

Several types of electric cautery are on the market. We have found it handy to have two; the heavy one is a 110-volt, 2-ampere machine, and the other is much smaller and lighter, but nevertheless very handy for all small growths.

CONCLUSION

The cautery should displace the use of caustics in practically all conditions, and frequently the knife as well.

DISCUSSION

Dr. Pusey said that we were indebted to Dr. Hazen for bringing up the matter of the use of the electric cautery in dermatology. In the last few years he had used the cautery more and more through the suggestion he had had from one man and another, and while he did not see the advantages of it over other methods of treatment, he did use it in some of the conditions mentioned by the essayist. He wanted to support the position taken as to its great convenience in removing many of the lesions of the skin that required complete and thorough removal. His chief reason for getting up was the fact that the essayist did not refer to the use of the electric cautery in removing xanthomas about the eyelids. He had his attention called to that by Dr. Darier of Springfield several years ago, and it proved a most excellent method of treating these lesions in his experience. He made small punctures through the lesion with the cautery. This method had given him excellent results in the treatment of such blemishes.

As to the removal of moles from the eyelid, he treated many lesions of the upper lid with the electric cautery, and he was sure from his experience that it may be used equally well for other lesions in that locality.

Dr. Wallhauser said he would like to say a word in reference to the use of the electric cautery in the conditions mentioned by Dr. Hazen. He had not employed it to any great extent in the last few years. He tried it in cases of lupus vulgaris in which he had had recurrences. It was not applicable to cases with extensive areas involved. It was only applicable in early cases, and even in early cases several deep applications were necessary. In the cases in which the lesions were advanced an inch or two he doubted whether it will be effective. In carcinoma or epithelioma it was particularly useful about the lids. He had had cases treated with the electric cautery ten years ago in which no recurrences had since developed. With the injection of novocain the lesion could be removed with one application. He had treated many cases of xanthoma palpebrarum with light applications.

Dr. Lieberthal said he was particularly interested in this paper because he had been using the thermo-cautery and had found it exceedingly valuable in the treatment of furuncles, using a very narrow tip. As soon as a yellow point in the center had developed, even if it was safe to puncture with the tip of the knife, the use of the cautery was valuable, and it was excellent in those cases where you have skin separated from the loose subcutaneous tissue; it did not matter how deep the process was, the effect would be excellent, especially on the mucous membranes. He found it a superior method of treatment in another condition, namely, rhinophyma. In this condition a much better cosmetic result could be achieved with the cautery than could be obtained with the knife. There was no danger of infection whatsoever.

Dr. Hazen said that in reference to lupus, he remembered one case in which the cheek was involved. A surgeon excised the whole patch with the cautery knife. The patch was a large one, and up to this time there had been no recurrence.

FURTHER STUDIES ON THE MODE OF ABSORPTION OF MERCURY IN THE INUNCTION TREATMENT OF SYPHILIS *

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In a previous publication[1] we detailed experiments bearing on the mode of absorption of mercury in the inunction treatment of syphilis. In this publication we experimented with various mercurial salts of low vapor pressure in order to determine whether such salts could be absorbed through the skin, under conditions which did not permit of their volatilization. Our experiments also included the use of the more volatile salts, that is, those of high vapor pressure. In order to determine whether these salts were actually absorbed through inhalation, we employed conditions which did not permit of their absorption through the skin. Our experiments taught us, and we concluded therefrom, that in the inunction treatment of syphilis, mercury is appreciably absorbed by direct diffusion through the skin and by volatilization and subsequent inhalation or diffusion. We were able, in our preliminary study, also to ascertain something as to the rapidity of absorption of the various salts, employing as an index of absorption the detection of mercury in the urine. Since our first publication the sensitiveness of our test has been elaborated so that at the present writing one-millionth of a grain of mercury in solution may be detected macroscopically by the test employed. This test has appeared as a separate publication by one of us (Elliott).[2]

In brief, the method of detection of mercury embodies the use of copper dust in an acid solution of the suspected material. The mercury is taken up to its last trace by the copper dust. The latter is then col-

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* Read before the Twenty-Fourth Annual Meeting of the American Dermatological Association, Cincinnati, May 24-26, 1917.

1. Wile, U. J., and Elliott, J. A.: Mode of Absorption of Mercury in the Inunction Treatment of Syphilis. Jour. Am. Med. Assn., April 7, 1917, p. 1024.

2. Elliott, J. A.: A New and Delicate Method for the Detection of Mercury, Jour. Am. Med. Assn., June 9, 1917, p. 1693.

lected, dried and heated in the distal end of a bulb-tube. The mercury is thus driven off and deposited as an amalgam on a small particle of dental gold leaf. By means of this test we have been able to detect most minute quantities of mercury in solution.

Our preliminary experiments led us to believe that blue ointment, or the unguentum hydrargyri, and calomel ointment of equal mercurial content, representing forms of mercury having a high vapor pressure, were far more readily absorbed and eliminated in larger quantities when anointed on the skin, than any other salts employed.

In the present series of experiments we have attempted a comparison of the absorbability and elimination, particularly of calomel ointment and blue ointment. It was our thought that if calomel were as readily absorbed and as readily eliminated as the blue ointment, one might conclude that its therapeutic effect would be equally as rapid. In this event its greater cleanliness might justify replacing the blue ointment in our therapeutic armamentarium. We also attempted to determine not only the presence of mercury from parallel inunctions of mercury ointment and calomel ointment in the urine, but we investigated further the various body fluids, such as the stomach contents, the saliva, the blood, the milk, and the spinal fluid. An investigation of the sweat was obviously impossible, owing to the fact that we were employing the inunction method of treatment.

EXPERIMENTS ON THE BLOOD

In determining the presence of mercury in the blood, it became necessary to employ a modification of the method used in determining its presence in the urine, owing to the large amount of organic matter present. This modification consisted in distilling by heat the blood with sulphuric acid to destroy organic matter, and testing for mercury in both distillate and residue.

In a series of experiments in which blue ointment and calomel had been rubbed on the skin, we were able to detect the mercury in the blood in the case of the blue ointment only after a considerable number of inunctions had been given. In the case of calomel we were unable to determine the presence of mercury in the blood as far as we tested, that is to say, it did not appear in the blood after the same number of inunctions with the blue ointment. From this experiment we concluded that mercury is eliminated into the blood stream more rapidly in the case of blue ointment than in the case of calomel.

As an incidental experiment we determined with great readiness the presence of mercury in the blood, following injections of salicylate of mercury, bichlorid of mercury, and succinimid of mercury. In the case of the sublimate, mercury was found after the third injection. In the case of the other two salts, both had been given a longer time,

although mercury was probably present in the blood before we tested for it.

EXPERIMENTS ON THE SPINAL FLUID

From the experiments on the spinal fluid we gathered most interesting data. We attempted the detection of mercury in many different experiments following inunction of both calomel and blue ointment, and following injections of mercury salicylate, succinimid, and bichlorid. In no case were we able to detect the faintest trace of mercury in the spinal fluid. Believing that perhaps the amount of fluid which we tested was too small, we collected fluid from several different cases that had been taking mercury in various forms for a long period of time. This experiment likewise proved negative. We were able, furthermore, to test the spinal fluid of a patient who died of mercurial poisoning from ingestion of sublimate. The spinal fluid in this case also failed to reveal the presence of mercury.

EXPERIMENTS ON THE MILK

The milk from various nursing women was tested following their inunction with both blue ointment and calomel. In both cases mercury in appreciable quantity was found as soon as tested for, that is, after one week of inunctions, and undoubtedly would have been shown to be present earlier had we had the opportunity of testing for it. To avoid the possibility that the milk had been contaminated by the skin, we placed nursing women on the injection treatment and found mercury in the milk forty-eight hours after injection with the bichlorid. From this experiment we may justly conclude that mercury is eliminated in very appreciable quantity by the lactiferous glands.

EXPERIMENTS ON THE SALIVA

It has long been known that mercury is eliminated through the salivary glands and that its presence gives rise to salivation in cases of overdosage of mercury. We investigated the saliva of patients receiving inunctions of both calomel and blue ointment and were able to detect mercury, although not in strikingly large quantities, in both instances. One case in which calomel ointment was used in connection with wet dressings of sublimate on an open syphilitic ulcer, yielded a very positive result in the saliva in the absence of any evident stomatitis or salivation. It may thus be concluded that the salivary glands excrete mercury even in the absence of excessive glandular activity.

EXPERIMENTS ON STOMACH CONTENTS

In washings from the stomach we were able to detect mercury following inunctions of both calomel and blue ointment. In both

cases, however, the tests were made after several inunctions had been given. It seems not unlikely that it would have been found earlier had we had the opportunity of making the tests. The question as to how much of the mercury in the stomach is actually eliminated there, and how much is due to the elimination through the saliva and subsequent swallowing, is a point which we have not had the opportunity, thus far, of deciding.

Owing to the volatilization of both calomel and blue ointment as shown in our first communication, the nasal secretion obviously did not lend itself to experimentation.

While we had no definite data as to the relative rapidity with which mercury may be determined following inunctions with calomel and blue ointment in the case of other body fluids, we have shown definitely that in the case of calomel, the elimination in the urine is much slower than it is with blue ointment. In general, we believe the mercury following the use of calomel appears later in the other body fluids as well.

With regard to the relative therapeutic value of calomel and blue ointment, we are not prepared to make a definite statement at this time. From our own observation and from communications from others who are using calomel in the form of inunctions, it would seem that its therapeutic effect stands favorable comparison with the therapeutic effect of the blue ointment. This fact is also not at variance with our findings, inasmuch as the slow absorption and elimination of mercury is perhaps more desirable than a rapid diffusion.

Complementary to experimental studies, further data should be forthcoming following a long series of clinical observations before the blue ointment should be discarded in favor of calomel ointment in the inunction treatment of syphilis. If such data will establish an equal therapeutic value for calomel, then it might well supersede blue ointment in our armamentarium as a cleaner method of anointing mercury.

DISCUSSION

Dr. Schamberg said that he had been much interested in the presentation of Dr. Wile and was glad he had presented this material because his series of experiments and theirs complemented each other. Their experiments were carried out on animals owing to the controversy that had existed for some time in Europe and elsewhere as to whether mercury could by inunction be absorbed through the skin and volatilized and absorbed through the lung. These box experiments could be best illustrated on the blackboard. This box (indicating) was practically air proof, with an aperture at one end fitted with an inlet, so that the rabbit could lie in the box with the head outside and breathe the external air. A central partition had a similar aperture through which to control the rabbit's head, the animal breathing the mercury laden atmosphere. The hair was removed by a depilatory and moist rubbing every few days. After four inunctions the anointed rabbit died. They found distinct evidences of mercurial nephritis in one or two rabbits, and their organs

were subjected to analysis for mercury. Mercury was invariably found in considerable quantities in the liver and kidneys of the anointed animal, but not in the lungs. With the control animal large amounts of mercury were found in the lungs, and little or none in the kidneys and liver. The control animal survived the period of experimentation and was killed. Animal A, the one breathing the outside air, nearly always died after massive inunctions.

From these experiments, which were repeated on six rabbits, they came to the definite conclusion that mercury may be absorbed through the skin, in the first place, and in the second place, giving inunctions, the dominating function of absorption was in the skin, but that mercury may likewise be absorbed through the lungs. (He doubted whether under ordinary conditions, that played nearly as large a factor as true cutaneous absorption.) Their experiment indicated that calomel was not volatilized to the extent that metallic mercury was and was less absorbed through the lungs than mercurial ointment. That could be counted on by using calomel inunctions in proportionately larger doses. Forty-five grains of calomel to one gram of lanolin and two grams of benzoated lard will be absorbed into any skin within ten minutes. This fact ought to restore mercurial inunctions to the place which they deserved. Inunctions were undoubtedly the safest method of giving mercury in massive form.

DR. WISE said he would like to ask Dr. Wile if the spinal fluid contained any mercury. If not, what his explanation was as to that phenomenon.

DR. WILE in answer to the question of Dr. Wise, said that there had been some preliminary work done in connection with salvarsan. Investigators had used that and found it was practically impossible to find arsenic in the spinal fluid following intravenous injections. Just why mercury was not excreted into the spinal fluid was a question of circulation of the spinal fluid concerning which we were still somewhat in doubt. He thought the next experiment which they will undertake, will be the determination of mercury in the brain and cord tissue. It would seem probable that the choroid plexus filtered out the salts of mercury.

A practical point which should be considered here, was the explanation of many cases of neural syphilis, notwithstanding the most energetic mercurial treatment given in the usual way, and it was a plea for the early treatment of syphilis of the spinal canal.

The other point concerned the elimination of mercury in the stomach. The nursing children of syphilitic mothers must derive benefit from the mercury eliminated through the mother's milk.

DR. POLLITZER said he would like to ask Dr. Wile if he perhaps could not make a determination of the presence of substances with small molecules. The salvarsan molecule was one of enormous size. The molecule of mercury was also of large size. If salts were used, with small molecular volume, such as a salt of ready diffusibility, as potassium or sodium iodid, it would be interesting to tell whether such salts were readily capable of passing through the choroid plexus. That would give us a distinct clue or, at least, an explanation of the failure of large molecular bodies to pass through the choroid plexus. In other words, it would explain the failure of salvarsan to do so.

DR. WILE said that they had used calomel which was put up by Parke, Davis & Company in equal strength. He was not prepared to make any statement as to its therapeutic value, but *a priori* one could use calomel in very high concentration. He used 7 per cent. calomel ointment.

DR. SCHAMBERG said that calomel contained 85 per cent. mercury. In a mercurial ointment, if equal parts of calomel and lard with mercury were used, from 50 to 85 per cent. would be the result, and because of that fact less absorption through the lungs with calomel took place. Personally he had used 45 grains of calomel to the inunction. That will give about the equivalent to the one dram of mercurial ointment.

THE COOLIDGE TUBE IN THE TREATMENT OF NON-MALIGNANT DISEASES OF THE SKIN*

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During the past thirteen years I have used the Roentgen ray in the treatment of various diseases of the skin. It is only during the past eighteen months, however, since I began to use the Coolidge tube, that my work with the Roentgen ray has given me any real satisfaction. Before adopting the Coolidge tube, my apparatus consisted of a static machine and tubes of uncertain and varying hardness with no meters or means of measuring or standardizing the dosage. With this unscientific apparatus the results were in general unsatisfactory, though in a few cases surprisingly good. While realizing for a long time that the Roentgen ray was a valuable therapeutic agent for skin diseases, I felt that without proper standardization its employment was always attended with considerable danger. At all events, I felt that I could not use it in large doses or as a routine measure with entire safety. With the new apparatus and technic, my opinion of Roentgen-ray therapy has entirely changed, and I may add that I have never made a change in therapeutic measures that compares in satisfaction with the change from the old to the new method of using Roentgen rays.

Like a number of my dermatologic colleagues, I have followed the technic elaborated by Dr. George M. MacKee, and wish to thank him for his personal aid and advice in my work. It may be a satisfaction for others like myself to learn that this new work is not difficult to acquire, and an extensive knowledge of radiology is unnecessary. The apparatus which has been used during the past eighteen months consists of a two-kilowatt transformer, fed by a 220-volt direct current, a Coolidge tube with its step-down transformer, a milliamperemeter, rheostat, etc. In practically every case the treatment has been given with the patient in a recumbent position on a low wooden table. A metal table was used at first, but discarded after the tube had been punctured by accidental contact with the metal of the tube stand.

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In standardizing the apparatus, which was kindly done by Dr. John Remer, a tube distance of 3.5 inches from bulb to skin (7 inches from anode to skin) was arbitrarily chosen. Using 3.5 milliamperes of current, a 7-inch parallel spark gap and the rheostat at a certain button (8th) it was found that an exposure of one minute, using a stop watch, gave a quantity of Roentgen ray of 1 unit measured by the Holzknecht radiometer. In using MacKee's technic, the pastille is placed on the skin and in speaking of 1 H. unit the words "skin distance" should be added. One H. unit obtained in this way is equivalent to 4 H. units when the pastille is placed midway between the tube and the skin. In this article when speaking of H. units or fractions thereof the words "skin distance" will be understood.

On account of the impossibility (due to the war) of obtaining a Holzknecht radiometer, it has been necessary to work without this instrument. In spite of this handicap my Roentgen-ray work has continued without any severe reactions, except in two cases in which large doses had been intentionally given. On account of the remarkable constancy of the Coolidge tube, it has been possible to treat cases of acne and eczema, for instance, in a routine manner, without the slightest uneasiness about the production of untoward results.

While the title of this paper refers to the Coolidge tube alone, my purpose is to advocate the use of measured dosage in Roentgen-ray therapy, the Coolidge tube being used, as it greatly assists in attaining this object. Indeed it is due to the remarkable constancy of the Coolidge tube that it has been possible to standardize my apparatus and dispense with the use of a radiometer. I appreciate, however, the value of using a radiometer and would certainly have employed the Holzknecht instrument for massive doses during the first eighteen months if it had been possible to obtain one. It is for this reason that the treatment of ringworm of the scalp by massive doses has not been undertaken, as in this disease the greatest possible accuracy in dosage is necessary. One of the greatest advantages of the Coolidge tube is that treatments can be given approximately in one tenth of the time consumed in using some of the old fashioned tubes. In spite of its great power it is entirely safe, owing to the constancy of its vacuum. It is, furthermore, very durable, lasting for years, and not being as liable to puncture as other tubes.

When using the Coolidge tube it is only necessary to measure (by the milliampere meter and the spark gap) the quantity of Roentgen ray, it being entirely proper to dispense with the apparatus (qualimeter) to determine the quality of the ray. There is another point about the Coolidge tube which has not been understood by some dermatologists. While the rays from this tube are very penetrating, they

can be so perfectly controlled that the tube is entirely safe and proper to use in superficial conditions, such as nonmalignant conditions of the skin. In spite of enthusiasm over my newly adopted technic, I am perfectly willing to admit that a few of my colleagues who have used the old fashioned methods, have attained splendid results and can use their apparatus with apparent safety. I feel, however, that in the future Roentgen-ray therapy should be practiced with every possible safeguard, which includes methods of measuring doses and using a Coolidge tube. We can then speak of treatment by units or fractions of units of a certain definite scale instead of talking about giving treatments of "ten minutes each at six inches from the skin," which conveys no real idea of the amount of Roentgen ray that has been used. I feel certain that the next generation of Roentgen-ray therapeutists will all adopt the newer methods of treatment and think it likely that before long the question of having used the safer technic may have a medicolegal bearing in cases of Roentgen-ray burns.

In regard to the various diseases of the skin that were treated, the best results were probably attained in eczema. This was particularly gratifying, as previous to the introduction of the new technic I had never treated any cases of eczema with the ray, and was somewhat skeptical about the reported results of others. All types of eczema were treated, except very acute ones with vesicles or edema. The cases varied from papular or vesicular eruptions of two weeks' duration to chronic thickened patches of thirty years' duration. Sixty cases in all were treated, of which thirty-one cleared up in a most gratifying manner, some of the results being strikingly good. In nine of these cases the eruption affected the palms or soles and cleared up much more rapidly than after any other treatment with which I am familiar. Two of the very favorable cases of eczema were children of 4 and 2.5 years, respectively. The results in four cases of eczema of the vulva and neighboring region were astonishingly good. A fine result was also obtained in a case of eczema of the scrotum of thirty years' duration, which had resisted all other methods of treatment. After a second treatment the itching was greatly relieved and the eczema was practically well after six treatments of 0.5 H. In sixteen cases the lesions were either entirely cleared up or greatly improved, but later relapsed to a greater or less extent. In many of these the relapsing lesions again disappeared shortly after treatment. In ten cases the results were indefinite, as the patients did not continue treatment long enough or with sufficient regularity. Three cases failed to respond to Roentgen-ray treatment after it had been given a fair trial. The dosage of Roentgen ray in the majority of cases of eczema was 0.5 H. at weekly intervals, treating as a rule no more than six separate areas

at one sitting. In one extensive case, however, eighteen areas were treated at one sitting. As a rule most of the patches of eczema were cleared up by three or four treatments of 0.5 H. each.

My experience with the Roentgen ray in psoriasis was in the main disappointing. The lesions themselves were easily cleared up, but they returned with discouraging frequency. The Roentgen ray appears to be especially useful for lesions of the hands and face where chrysarobin is objectionable and for localized patches of psoriasis. It is, however, in my opinion a less valuable remedy than chrysarobin for the treatment of psoriasis. Its value in psoriasis is certainly below that in eczema. Of nineteen cases of psoriasis treated, the results in eight were distinctly favorable. In one case there was no relapse at the end of a year, and in another none at the end of ten months. In another case a patch on the elbow, of fifteen years' duration, disappeared in four days after one massive dose of 1.5 H. In another case a patch on the abdomen which had been resistant to chrysarobin ointment (vigorously applied and covered by rubber cloth) disappeared after five treatments of 0.5 H. One case of psoriasis of the palms showed gratifying improvement. Five cases, one of which had received twelve and another seventeen treatments, showed temporary improvement, but frequent relapses. In six cases the results were unsatisfactory on account of sufficient or irregular treatments. In one case a severe dermatitis followed the very unwise plan of attempting to hurry the treatment to accomodate the patient, whose sojourn in town was short.

In six cases of seborrheic eczema, four showed excellent results. One patient presented lesions of six months' duration on the glans penis. They disappeared entirely after five weekly treatments of 0.5 H. units.

The results obtained in acne were highly satisfactory, forty cases having been treated. In twelve cases the action of the ray was most gratifying, all of the lesions clearing up completely or nearly so by treatment with the Roentgen ray alone. All of these cases exhibited better results than could have been attained, in my opinion, by other methods of treatment, such as soap frictions, curettage, sulphur lotions, vaccines, etc. These cases were given an average of nearly eight exposures and generally showed the first decided improvement shortly after the fifth treatment. The dosage was 0.25 H., at weekly intervals. In twenty-four cases the results were very good, certainly equal to those obtained by other methods. Of the four remaining cases, two were entirely refractory to treatment and two others discontinued their visits too early. All types and grades of severity were treated, the severer cases naturally showing the more striking change in appearance. From my personal experience I now consider the Roentgen ray

as the most efficient agent for the treatment of acne, and with the modern measured dosage, do not hesitate to treat any case of acne, whether occurring on the back of an older person or the face of a young girl.

Six cases of rosacea were treated, all receiving 0.25 H. units at weekly intervals. Three of them received five treatments with no benefit whatever. Three other cases receiving five, six and eight treatments, respectively, showed some improvement. Two of these were of the pustular type, whereas the first three, showing no improvement, were of the erythematous type.

Of seven cases of lichen planus treated, five were of the ordinary and two of the hypertrophic type. In the first mentioned group the result of treatment was very satisfactory, the Roentgen ray not only stopping the itching, but causing a gradual disappearance of the lesions. Indeed, the Roentgen ray appears to me to be the only local remedy that causes involution of lesions of ordinary lichen planus. Other local remedies do no more than stop itching. One of the two cases of hypertrophic lichen planus responded favorably to treatment, two markedly elevated lesions (one of them ¾ inch) being entirely flattened by the Roentgen ray. The result in the second case was not satisfactory, in spite of pushing the treatment till a well marked erythema had been obtained.

Roentgen-ray treatment of five cases of lichen circumscriptus was extremely satisfactory. One patient presented circumscribed, infiltrated patches on either side of the vulva and inguinal region, the larger patch measuring 5 by 2½ inches. They had existed for five years. After a single treatment of 1 H. unit, the lesions gradually cleared up, and one month later there was no trace of the former lesions except a slight pigmentation.

Five cases of sycosis were treated with good results. In one case, a man aged 70, the eruption had existed continuously, according to his statement, for fifty years. He was given fractional doses of Roentgen ray, receiving altogether 5.75 H. units in the course of four months. At the end of this treatment the skin was entirely normal and has remained so up to the present (four months). The cases of sycosis were treated by 0.25 H. units, increasing to 0.5 H. when necessary. Two cases of folliculitis of the neck were treated with distinctly poor result.

Three cases of pruritus cutaneus were treated. In one case there had been distressing itching of the vulva and anus for four years. Four days after a single treatment of 1 H. unit the itching stopped almost entirely. Ten weeks later she was given another massive dose, and for the past nine months she had been entirely free from pruritus.

Two other cases of simple pruritus of the trunk and extremities were favorably affected. The antipruritic effect of the Roentgen ray is of course well known, itching often stopping on the second or third day after treatment in cases of eczema, psoriasis, lichen planus, etc.

Two cases of paronychia were treated, one of them showing some improvement. Unsatisfactory results were obtained in two cases of verruca vulgaris (one case involving the nail), four cases of dermatitis herpetiformis, one case of hypertrophic scar and one of extensive sarcoid. The case of sarcoid consisted of a dozen lesions involving the face, trunk and extremities. The patient was treated with the Roentgen ray at a time when a diagnosis of mycosis fungoides seemed probable and before the disease had been proved microscopically to be sarcoid. During three months a total of 2.25 H. units were given to the lesions of the face and upper extremities, and a total of 3.125 H. units to the lesions of the trunk. The same lesions were later treated by carbon dioxid snow with favorable result.

In conclusion, I cannot urge too strongly the adoption of a system of measured dosage and the use of the Coolidge tube in Roentgen-ray therapy. The Coolidge tube is constant, safe, rapid and durable, and is eminently suited for treating superficial conditions, such as non-malignant diseases of the skin.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, Dec. 19, 1916

JAMES C. JOHNSTON, M.D., *President*

LYMPHANGIOMA CIRCUMSCRIPTUM. PRESENTED BY DR. TRIMBLE

The patient was a young girl, aged 14 years, of Russian parentage, born in the United States.

On the outer side of the right thigh, over an area about the size of the hand, were a number of lymph vesicles, ranging in size from a pinhead to a split pea. There were also numerous telangiectases and minute angiomas. The area affected was thick and brawny to the touch; the condition had existed since early infancy.

DISCUSSION

DR. CLARK said that it was a typical case, though not appearing in the usual location. Most of the cases he had seen developed around the neck or on the body.

LEUKODERMA PSORIATICUM. PRESENTED BY DR. HEIMANN FOR DR. FORDYCE

This was presented as a possible case of leukoderma psoriaticum in a girl of 18, who had had psoriasis for a year and a half. The leukodermatous spots had appeared on the back and had persisted without change in the condition of the lesions nor in the depigmentation. The main thing to be considered differentially was the depigmentation that followed the use of chrysarobin. The case was presented with the diagnosis in question, with all due reservation.

DISCUSSION

DR. WHITEHOUSE said that it impressed him as being simply a contrast between the hyperpigmented skin and the other, perhaps as the result of the application of the chrysarobin to the psoriasis, and that a few weeks might eliminate it. The patch of psoriasis then present would seem to bear that out, and probably eventually the pigment would be distributed normally over the skin and be restored entirely.

DR. SHERWELL agreed with Dr. Whitehouse that it was simply a temporary condition due to the use of chrysarobin.

DR. HOWARD FOX thought the patient simply presented the appearance of a psoriatic who had been successfully treated by chrysarobin.

DRS. TRIMBLE AND SCHWARTZ agreed with the previous speakers.

DR. HEIMANN said that it was rather a difficult thesis to defend. The case was presented first because there was room for conjecture as to whether it was a case of pigmentation following the chrysarobin or whether it was actually one of psoriatic leukoderma. It was six or seven weeks since the patient had used the chrysarobin, and during that period she had been under observation, and there had been no change in the condition. There were never any signs of inflammation in the white areas, such as one would have after the application of chrysarobin, and no history of having recently used chrysarobin; so that it seemed fair to regard it as psoriatic leukoderma. The question could

be decided definitely only after long observation, and he would present it again later.

LUPUS VULGARIS TREATED BY ROENTGEN RAY. PRESENTED BY DR. CLARK

Dr. Clark said that having done a great deal of work with the Kromayer light, he had come to realize that there were certain cases of lupus vulgaris in which the light was absolutely ineffectual—that is, the granular, nodular, rather thick type, where the tissue resembled granulation tissue. In this instance the patient had lupus vulgaris lesions on the cheek, which were treated by the Kromayer light and which disappeared. Eighteen months later the patient reappeared with a very extensive lupus vulgaris of the nose, involving the sides, tip and nasal orifices. She was given a single massive dose of the Roentgen ray, and the results were very good, as could be seen. In this type of lupus vulgaris the Roentgen-ray treatment was more satisfactory than any other.

Some time later the patient presented a very active granular lupus vulgaris on the border of the lips, on the mucous membranes of the inner surface of the lips and the gingival mucous membranes. This also was treated with a a massive dose of Roentgen ray, and the condition was very much improved. The speaker said that according to his experience lupus vulgaris in this particular region was very difficult to cure, but he had reason to believe that if this lesion received another massive dose of Roentgen ray, it also would disappear. It was already 70 to 80 per cent. better than when first seen.

DISCUSSION

DR. WHITEHOUSE said that the result of the Roentgen-ray treatment was very satisfactory, and he did not know of any better way of treating that condition of the gums. It was certainly very gratifying to get such a result.

Referring to the Kromayer light, the speaker said that he had had a patient with a lesion on the forearm which acted in the same manner under the Kromayer lamp. The lesion had disappeared entirely, rather to his surprise. It was about six or eight weeks before the scab fell off, and some three or four weeks later before it paled out, leaving only a scar. In certain types of lupus vulgaris, the Kromayer quartz lamp was very effective.

DR. CLARK, replying to Dr. MacKee, said that the patch on the cheek was treated with two applications of the Kromayer lamp, but that the condition on the cheek was very different from the lesion on the mucous membrane and the nose. It was much more superficial, with a few superficial nodules around the edge and scattered through the patch. The patch on the nose and the gingival mucous membrane was distinctly granular in type, and on such lesions the Kromayer light had not produced any effect. The Roentgen-ray dosage to the mucous membranes was a scant two units. The patient had a very sore face, and it was a question as to whether the mucous membrane would not slough over the gum, but the inflammation subsided. In the face of this result, he felt justified in giving the patient a slight modification of the former dosage with the upper lip pinned back, to see if the remaining lesions on the gingival mucous membranes could be cleared up. The lesion went through the usual course of blister and crust, the crust disappearing in six weeks. At the end of that time another application was made, and that healed in the same manner. The application was made with a two millimeter blue filter with a practically new arc. That factor was very important in the Kromayer light applications. The quartz arc clouded very quickly, and it had to be renewed several times a year. The speaker said that when he was treating a great many clinical cases he discovered that the least cloud on the quartz arc would diminish the number of ultraviolet rays tremendously. There would be just as much reaction, but you would not get the result from the violet rays.

GUMMATA APPEARING IN PSORIATIC PATCHES. PRESENTED BY DR. WISE FOR DR. FORDYCE

John C., laborer, aged 34, was born in the United States. The patient had been married six years and had three children. One died at three months, of bronchitis, the others were healthy and well.

On his right arm there was what appeared to be a typical eruption of psoriasis guttata; on the inner aspect of the left arm was an unbroken gumma, the size of an olive, the overlying skin being purple and scaly. Close to this, and in marked contrast, was a circular, non-infiltrated, pale red, scaly eruption —a typical psoriasis patch. On the anterior surface of the left forearm, extending from the bend of the elbow to an inch above the wrist, was a pale red eruption of irregular outline, consisting of two large palm-sized patches, connected by an intervening bridge of diseased skin. This eruption was characteristically psoriatic. The upper border of the eruption was distinctly infiltrated, and within it was a gummatous ulcer the size and shape of a lima bean. On both patches of psoriasis were thick, finely adherent, grayish black scales, under which syphilitic ulceration was apparent.

DISCUSSION

DR. KINGSBURY said that judging from the appearance of the forearms with the gummatous infiltration, the condition seemed to be all syphilis; but that the lesions on the other arm and on the scalp seemed to indicate that the man was a syphilitic psoriatic.

DR. POTTER agreed with Dr. Kingsbury that the patient was both syphilitic and psoriatic. Looking at the forearm alone, one might think it to be all syphilis; but on examining the body it was quite evident that both psoriasis and syphilis existed.

DR. WHITEHOUSE agreed with Dr. Wise's conception of the case that two diseases were present.

DR. CLARK said that it was very interesting to see the modification of the superimposed disease. It was apparently an old psoriasis with a superimposed syphilis.

DR. WINFIELD told of an interesting case which he had under observation a few years ago. The patient was a psoriatic who contracted syphilis. The psoriatic lesions became more indurated. He recovered entirely from the psoriatic attack after the administration of salvarsan.

SYRINGO-CYSTADENOMA. PRESENTED BY DR. CLARK

The patient was a man, 44 years of age, born in the United States. When he was a youngster, he first noticed some spots on his body. On presentation they appeared as little, round, pinkish or flesh colored papules, and none had ever disappeared. They were firm nodules, varying in size from pin head to pea size, appearing mainly on the chest, arms and neck. They had not produced subjective symptoms. The patient said that an older sister had the same lesions on the chest and neck.

DISCUSSION

DR. CLARK said that this was evidently the same condition shown by Dr. Fox's patient at the last meeting, and was the third case of the kind he had ever seen.

DRS. WINFIELD, WHITEHOUSE, FOX AND WISE agreed with the diagnosis.

DR. MACKEE agreed with the diagnosis of the so-called syringocystadenoma, but said that if the lesions were studied microscopically, one could not distinguish between them and benign cystic epithelioma. When the lesions occurred on the body they were usually called syringocystadenoma, and when they appeared on the face they were termed benign cystoma.

Referring to the treatment, he said that at present they had a patient under Roentgen-ray treatment at the Vanderbilt Clinic. The lesions had flattened down to the level of the skin after four treatments, each of one unit. She would probably not require any more treatments. He therefore suggested Roentgen-ray treatment of this case.

LARVA MIGRANS: PRESENTATION OF PHOTOGRAPHS. By Dr. Howard Fox

The recent case of larva migrans presented by Dr. Whitehouse had aroused interest in this subject. The speaker had lately seen a case in a soldier who had returned from the Mexican border. Under ordinary circumstances he would not have thought of the possibility of creeping eruption. The patient presented an elevated, urticarial, irregular, linear lesion on the back, about three-quarters of an inch in length. About half an inch from one end of this lesion was another little pinhead urticarial spot, which was doubtless the beginning of a second burrow. In view of Dr. Whitehouse's experience, the patient was given epicarin ointment, which had failed to effect a cure at the end of two weeks. The speaker presented a photograph kindly sent by Dr. Kirby-Smith of Jacksonville, of a man with a large number of lesions scattered over the back. A second photograph of a characteristic linear lesion on the ankle was shown through the courtesy of Captain McCullagh of Squadron A. In the first case the eruption had existed eight days; in the second, about two and a half months. For the treatment of the disease, Dr. Kirby-Smith recommended as the most efficient procedure, shaving the affected epidermis with the body of a sharp scalpel and then applying iodin or carbolic acid. Much less efficacious methods were high frequency sparks and freezing with carbon dioxid snow. Excision of the spreading burrow was the method of treatment suggested by Dr. Frank C. Knowles in a personal communication.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Nov. 21, 1916

Udo J. Wile, M.D., *President*

NEVUS. Presented by Dr. Pardee

The patient was a baby, 4 months old. The lesion extended from behind the left ear forward on to the cheek. The color was distinctly yellowish, did not disappear on pressure and showed no telangiectasis. That there were dilated capillaries connected with the lesion was, however, evident as it became considerably redder than the surrounding skin when the child cried. It resembled the description given by Crocker of "milium congenitale" but lacked the surrounding comedones mentioned in his case.

MULTIPLE SARCOMATOSIS CUTIS. Presented by Dr. Ormsby

The patient was a man, aged 52 years. He had had the disease for four months. The first lesion appeared on the lower right thorax. It began as a bluish-red spot, which gradually enlarged and became a tumor. This was rapidly followed by many tumors over the entire body. It was thought to be due to drinking water. There was no subjective sensation.

The patient was a pale man, showing debilitation. On the right side of the abdomen, just above the umbilicus, was the original tumor, dollar-sized, elevated, round, hard and yellowish-red in the center with a red periphery. Numerous other tumors were scattered everywhere. Over the back were closely-set, bluish-red areas, in all stages from mere macules to beginning tumors. There was adenopathy in all groups. The tonsils were somewhat enlarged. The blood examination showed: leukocytes, 6,800; hemoglobin, 70 per cent.; blood

pressure, 98, Tycos, sitting; temperature, 98.5 F.; urine, negative. Wassermann test negative.

A well developed tumor was removed from the upper left back on November 10; the wound was dressed and the stitches removed November 14. The incision was completely healed on November 17. Examination corroborated the clinical findings.

DISCUSSION

DR. PUSEY believed the case to be one of multiple sarcoma, but was struck with the unusual red appearance of the lesions and the peculiar mottled appearance of the patient's skin—almost like a roseola. He had seen multiple sarcoma of the skin with numerous subcutaneous tumors which gave the surface a mottled appearance, but he had never seen such a roseola-like appearance as this case showed. The microscopic picture was, of course, that of sarcoma.

DRS. MCEWEN, SHAFFNER AND BAER thought it was a sarcoma.

SPOROTRICHOSIS. PRESENTED BY DR. MOORE

The patient was a boy, aged 13 years, who was bitten on the index finger of his left hand by a field mouse, early in September, 1916, while in North Dakota. The wound healed readily. About three weeks later the first phalanx of this finger became swollen, reddened, firm but not very painful. Two weeks later the swelling "came to a head" and discharged a fairly large amount of yellowish pus.

About October 19 a nodular swelling was discovered 5 cm. above the wrist on the radial side of the forearm. A physician enlarged the opening on the finger and applied wet dressings. The condition did not improve but on the contrary the nodular swellings increased in number.

On November 5 he called on Dr. W. K. Yeakel, who sent him to the speaker for cultures. Cultures were made by Dr. D. J. Davis and Dr. Moore on November 6, and contained good growths of the sporothrix Schenckii, on November 11. On November 11, some yellowish honey-like pus was aspirated from the large nodule just above the wrist and pure cultures of the same organism were obtained in three days. Agglutination tests were positive in 1:160 dilution with homologous and heterologous organisms, including strains from France (sp. Beurmannii) and one isolated from a horse. Complement fixation tests were positive with antigens prepared from the same strains.

On examination on November 13, there was an irregular ulcer with undermined edge on the palmar surface of the index finger, which was swollen and reddened. Fifteen or more small, subcutaneous nodules were seen, commencing 2.5 cm. below the wrist on the dorsum of the hand and extending along the radial lymphatics to about 12.5 cm. above the elbow, varying in size from 0.5 to 2.5 cm. Most of them were firm but a few were softened, the latter having a bluish color. The lymph glands were not involved.

The patient had had no general symptoms, the temperature being normal; the white blood count was 10,500 with a normal differential picture. He was then receiving 30 gr. of potassium iodid, daily.

DISCUSSION

DR. MCEWEN thought it was unusual for the case to show such little evidence of inflammation. In other cases he had seen the nodules had been red.

DR. PUSEY regretted that there was no smear or culture shown with the case. He thought the glands would break down.

DR. ORMSBY was much interested in the case because of the fact that the last work Dr. Hyde did was on such a case, also from North Dakota. In his opinion the record of this case by Dr. Hyde and Dr. Davis established many important facts concerning American cases of sporotrichosis.

ALOPECIA AREATA ASSOCIATED WITH LUPUS ERYTHEMATOSUS. PRESENTED BY DR. SHAFFNER

The patient was a young man, aged 26 years, who had had the trouble for three years. He presented typical patches of lupus erythematosus on the cheeks and several areas on the scalp. Further, he had areas of various sizes and shapes of total baldness on the scalp, the scalp in these areas being apparently normal. The patient stated that hair had grown and fallen out in these patches at various times.

He presented a perforation of the septum pronounced by a rhinologist to be idiopathic, neither tuberculous nor syphilitic. His Wassermann and history were negative as to lues.

DISCUSSION

DR. MCEWEN believed it was a combination of lupus erythematosus and alopecia areata. The linear arrangement of some of the lesions did not necessarily argue against alopecia areata since such a condition could arise from the merging of a number of small areas which happened to be in alignment.

DR. PUSEY thought the patches were not alopecia areata. He considered the lupus erythematosus sufficient to account for the whole picture, and thought the fact that there was not much scarring did not matter.

DR. HARRIS thought the fact that the hair reappeared did not agree with lupus erythematosus and asked how the alopecia could be explained under those circumstances. He thought the lesions on the cheek and some of those on the scalp were lupus erythematosus and the other scalp lesions he considered alopecia areata.

DR. WILE was inclined to agree with Dr. Pusey that lupus erythematosus could account for the whole thing.

DR. SHAFFNER considered the case to represent two distinct conditions, alopecia areata and lupus erythematosus. The areas on the face were typical lupus erythematosus as were several red, atrophic patches on the scalp. The patches of alopecia and normal skin with baldness on the scalp were probably alopecia areata.

LUPUS ERYTHEMATOSUS IN A LUETIC. PRESENTED BY DR. POTTHOFF

This case was shown by Dr. Ormsby at the October meeting and was exhibited again to show the lack of benefit derived from antisyphilitic treatment.

The syphilitic history dated back eighteen years. One or two years ago the patient had an eruption on the ears which spread to the face, areas over the zygomatic process and malar bones, also over the nose, involving the bridge and alæ. The lesions were covered with dirty-grayish, adherent scales, irregular in shape and slightly elevated. This patient had received intensive syphilitic treatment for the last two months and showed very little improvement in the lesions.

CASE FOR DIAGNOSIS. PRESENTED BY DR. E. P. ZEISLER

The patient was a young woman, aged 29 years, who had had an eruption for a year and two months. According to her statement it grew worse either before or after the menstrual period. The eruption itched severely for a few days and then the itching disappeared. It was quite inflammatory at the time of menstruation. It was apparently a purely macular eruption and had never faded during the year and two months.

The possibilities to consider in this case were the premycotic stage of mycosis fungoides, dermatitis dysmenorrhœica (Polland) and a parakeratosis variegata.

DISCUSSION

DR. FOERSTER thought it resembled the case described by Kreibich in connection with menstruation.

DR. MCEWEN believed the diagnosis was a beginning mycosis fungoides.

DR. SHAFFNER thought in view of the fact that the lesions had been present for three or four years, with several remissions and that the patient had had her menstrual periods delayed until she was 20 years old, that the case was one of dermatitis dysmenorrhœica, recently described abroad.

DR. HARRIS had seen the case twice before, once about a week after her menstrual period. She had had an attack three years ago and then was free for a time but then had had the trouble for a year and two months. When he saw the patches they were distinctly elevated, brownish-red in color, some of them were vesicular at times, but he had not seen them in that condition. He considered it the same picture that was seen in erythema multiforme and did not know whether it belonged to the dermatitis dysmenorrhœica group or not. The lesions left a very distinct pigmentation and he did not think they were self-inflicted. She had a lesion on the side of the mouth when he first saw her.

DR. ZEISLER said he had seen the case on two occasions and the patient had been studied carefully from the internist's standpoint, at Wesley Hospital, with no definite conclusions. He thought the exacerbation at the time of the menstrual period was simply accidental. In their office they were impressed with the case as being an early one of mycosis fungoides.

DR. ORMSBY was interested in the question of dermatitis dysmenorrhœica, for the reason that he had gone over the literature a year or two ago and concluded that most of these cases were factitious. This case did not have the appearance of being factitious, nor did it correspond to the description of dermatitis dysmenorrhœica, and he was at a loss to make a diagnosis. There seemed to be some connection between the eruptive symptoms and the menstrual epoch.

CASE FOR DIAGNOSIS. PRESENTED BY DR. HARRIS

The patient was a young woman, aged 23 years. She had scarlet fever at the age of 12, and two and a half years later developed a condition inside the nose which caused crusting and interfered with breathing. Three years later the external lesions began as painless lumps in the skin. In two months these ruptured, discharging pus. The ulcers healed in a month under local treatment and cod liver oil. There was perforation of the cartilaginous septum. The Wassermann test was negative.

DISCUSSION

DR. ORMSBY stated that within the past two or three years he had seen a patient with an identical lesion on the side of the nose which had impressed him as being syphilis, but after watching it there was no doubt that the diagnosis was lupus erythematosus.

DR. SIMPSON believed the lesions on the nose to be lupus vulgaris.

DR. HARRIS thought the case looked like syphilis but the Wassermann was negative and treatment with salvarsan had had no effect on the lesions.

CASE FOR DIAGNOSIS. PRESENTED BY DR. ORMSBY

The patient was a man, aged 28 years, who presented a generalized eruption of three weeks' duration. The lesions were generally distributed, and occurred as well-defined, oval and round areas of dermatitis, resembling in many situations the lesions of pityriasis rosea, and in others those of seborrheic dermatitis. Neither disease was truly represented. The lesions were more red and scaling different from that of the typical pityriasis rosea lesion, and

they did not present the greasy scaling normally seen in dermatitis seborrheica. They presented a type seen during the past two years in a number of cases that were difficult to place clearly in any catalogue.

DISCUSSION

DR. PARDEE believed the case was one of pityriasis rosea.

DR. SIMPSON considered the case one of so-called herpes tonsurans maculosus. The involvement of the axilla and crural region made him think this should be the diagnosis. He thought there were two types of cases; one corresponding to pityriasis rosea and one to herpes tonsurans maculosus.

DR. HARRIS was much interested in the case because it was so like other cases that had been shown and diagnosed as pityriasis rosea or seborrheic dermatitis. This case showed a spot in the axilla which looked like an eczema which was almost ready to weep. He had seen cases clear up under sulphur and ichthyol, after three weeks.

DR. BAER thought the case was a seborrheic dermatitis.

DR. SHAFFNER considered it a case of pityriasis rosea.

DR. MCEWEN did not believe it was a pityriasis rosea, but did consider it as probably a parasitic affair.

DR. PUSEY thought the diagnosis in such cases rested between pityriasis rosea and seborrheic dermatitis, and that in such border line cases a differential diagnosis might be impossible. He had no doubt that the diagnosis lay between the two.

DR. FOERSTER said that at the Paris Congress in 1900, the French called all such cases pityriasis rosea while the Vienna school called them herpes tonsurans maculosus.

DR. WILE thought that if the lesions had no tendency to confluence no one would hesitate to call the case pityriasis rosea. He recalled a case which he had reported several years ago, in which vesicular lesions, on clearing up, proved to be a pityriasis rosea. They involved not only the skin but the mucous membranes. He thought that we should get away from the idea that all lesions are necessarily typical. He considered the case an atypical pityriasis rosea.

DR. E. P. ZEISLER said that they had recently observed an identical eruption in a physician who had made a diagnosis of syphilis on himself and had given himself two injections of salvarsan. As the injections had no effect on the eruption he took the trouble to find out what it really was and learned that he had a pityriasis rosea.

DR. ORMSBY stated that the patient had had a sulphur ointment for one week and there was no change, except that the lesions appeared to be irritated and showed no tendency to clear.*

TUMORS FOLLOWING INJECTIONS OF VASELIN. PRESENTED BY DR. ORMSBY

The patient was a man, aged 36 years, who had had the disorder for eight years. Chesebrough's white vaselin had been injected to fill depressions in the face, eight years ago, in Los Angeles. The first changes noted appeared between two and three years after the injection.

Each cheek beneath the eyes was the seat of nodules of various sizes. There was slight discoloration over the areas and marked infiltration. No telangiectatic vessels were present as yet, and there were no subjective sensations.

DISCUSSION

DR. PUSEY thought the case was very interesting and that it was not merely the vaselin but the irritating effects of a foreign material. He thought some-

* One week later, the entire eruption cleared under the same treatment.

body ought to make a scare-head of this subject in the newspapers and send the fellows who did such things to the penitentiary.

DR. ORMSBY said that such cases as the result of paraffin injections were not very rare, but he thought that this was the first vaselin case which had been shown here. The work was done in California, and the woman who did it had injected a number of patients. Another interesting feature was that the paraffin cases commonly began to develop in from five to fifteen months following the injection, but in this case the nodules had not appeared until three years after the vaselin had been injected.

CASE FOR DIAGNOSIS. PRESENTED BY DR. HARRIS

The patient was a young man, aged 31 years, who presented localized reddening of the upper lip and chin.

DISCUSSION

DR. ORMSBY thought the case was a very mild seborrheic dermatitis.

DR. PARDEE was much interested in this because he had an identical case. The lesions were practically the same as this man's but in his case the subjective symptoms were much more severe. It never developed anything like a sycosis and had nothing whatever to do with a seborrheic condition, which had cleared up in his case.

NEVOID KERATODERMIA. PRESENTED BY DR. ORMSBY

The patient was a young man, aged 20 years, who presented areas of marked keratosis on the palms and soles. The lesions, while chiefly on the palms and soles, were not limited to these regions, as a few nevus-like papules were grouped about the hips and on the anus. In addition to plaques of extreme hyperkeratosis on the palms and soles, there were lines of nevoid papules extending over the palms. The extreme development of the lesions rendered walking practically impossible and the hands also were nearly useless. The patient was undeveloped, and appeared much younger than his years indicated.

There were no other members of the family affected.

DISCUSSION

DR. PUSEY considered it a case of congenital keratodermia, differing from typical cases in that it was not so extensive as was usual. He had seen all degrees of such conditions. It looked exactly like nevus hystrix, and he thought it was not different except for the unusual location of the lesions.

CASE FOR DIAGNOSIS. PRESENTED BY DR. STILLIANS

The patient was a woman, aged 37 years, who had had a lesion on the back of her right hand for twenty-three years. There were no subjective symptoms and no similar lesions on her body. She was under treatment for syphilis of seven years' duration.

The patient exhibited a linear lesion extending from the base of the right index finger almost to the wrist and which was composed of hard, flat papules, confluent at the center of the lesion and discrete at the ends, somewhat hyperkeratosis at the top. The lesion was very slightly reddened except when irritated by her occupation of scrubbing.

DISCUSSION

DR. ORMSBY considered it an example of hypertrophic lichen planus.

DR. HARRIS did not know whether it was a lichen planus or a linear hyperkeratosis.

DR. STILLIANS thought it was a lichen planus but was not sure, because no typical lesions of lichen planus were to be found.

DERMATITIS FACTITIA. PRESENTED BY DR. STILLIANS

The patient was a young woman, aged 23 years, who was operated on about a year ago for tumors of the peritoneum. She had complained for five months of a burning and swelling in the left breast with hemorrhagic spots which ruptured after a few hours and discharged blood or bloody serum. She claimed to have had a temperature of 101 F. or 102 F. on several occasions before these lesions appeared and always to have felt drowsy for a day or so beforehand. She had an area of brownish discoloration on the upper half of the left breast, extending beyond the median line, and just above the nipple an excoriated area about an inch and a half in diameter. There was an anesthesia of the pharynx and tremor of the lids when closed, but no limitation of visual fields or areas of anesthesia were found on examination.

The lesion at the time of first examination was dry. The patient was given a microscopic slide and asked to make a smear of the discharge from this lesion. This smear on examination showed a few blood cells with an immense number of bacteria of various kinds.

DISCUSSION

DR. FOERSTER thought the lesion was distinctly self-inflicted. It had all the characteristics of a friction excoriation.

DR. SIMPSON believed it was entirely self-inflicted.

DR. STILLIANS suspected that the lesion was self-inflicted when the patient first presented herself and his suspicion was confirmed by the number of bacteria in the smear, which was possibly made from vaginal discharge.

VERRUCOUS SYPHILID OF ARM. PRESENTED BY DR. STILLIANS

A teamster of 18 years had his first secondary symptoms two months before. On presentation, he showed a psoriasiform syphilid over the body, and on the left elbow a flat, verrucous lesion, two inches in diameter. The patient was quite cachectic at first, but had improved a great deal under treatment. His lesions were slowly regressing.

Review of Dermatology and Syphilis

Under the direction of Fred Wise, M.D., New York

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BRITISH JOURNAL OF DERMATOLOGY

(*October-December, 1916, 28, Nos. 10-12*)

Abstracted by I. Rosen, M.D.

LIVEDO RETICULARIS. H. G. Adamson, p. 281.

The author uses this term to distinguish local or limited blue colorations of the skin, from cyanosis or universal colorations. This condition is more often seen among dispensary patients than in private practice.

The anatomy is best explained by Renaut, who demonstrated the arrangement of the vessels of the skin by injecting Prussian blue. This produced rounded blue patches, separated by pale tracts. These pale tracts became colored on continuing the injection. Each of the little areas corresponding to the blue patches represents the base of a vascular cone, which is fed by a deep artery at its apex. These round areas Renaut styled areas of "maximum circulation," and the intermediate tracts were regions of reduced circulation. It therefore follows from this anatomic arrangement that active hyperemia will cause flushing of the areas of maximum circulation and so the red patches; and that a venous stasis will produce a dusky network (livedo reticularis), corresponding to the areas of reduced circulation.

Persistent and pronounced livedo annularis may be associated with various illnesses, especially tuberculosis or a tuberculous tendency. It may also be found in children with congenital syphilis, myxedema, and among mongolian idiots, scrofulous and rachitic children.

Of the reticulated livedo-like eruptions, or inflammatory livedo, we have the following forms: (*a*) Erythema ab igne and ephilis ab igne. (*b*) Livedo-like eruptions associated with rheumatism, visceral and nervous troubles, and with tuberculosis. (*c*) Livedo-like eruptions associated with syphilis. (*d*) Cases of Bazin's disease presenting a livedo-like pattern.

The author's conclusions are as follows:

1. The dusky marbling or network known as livedo annularis is a result of the tuft-like arrangement of the blood vessels of the skin.

2. It may occur in many normal children and young adults, and is exaggerated as a result of exposure to cold.

3. In departure from health due to tuberculosis, syphilis, rheumatism, alcoholism, hypothyroidism, etc., the normal livedo annularis may become exaggerated and persistent, as has been suggested from a toxic action on the splanchnic plexus.

4. In persons with persistent and exaggerated livedo, the position and pattern of the eruptions due to syphilis and tuberculosis may be determined by the livedo, so that the eruption assumes a network aspect and may be called "inflammatory livedo."

5. A similar inflammatory livedo, with subsequent pigmentation, may be produced by prolonged exposure of the skin to heat—livedo a calore.

6. The distribution and arrangement of certain eruptions, such as those of secondary syphilis, measles, parakeratosis variegata, is explained by the anatomic arrangement of the blood vessels of the skin which give rise to livedo annularis.

RADIUM TREATMENT OF LUPUS VULGARIS. PAUL HASLUND, p. 294.

The author states that in the majority of cases under his observation treated with radium, the results were not favorable. Even if an unquestionable improvement has been demonstrable in some patients, it took a long time before it occurred, or it was followed by retrogression, or absolute standstill, so that it was advisable to discontinue the treatment. In some cases it did not influence the disease at all.

In comparing the results with that of the Finsen light, the latter therapeutic measure is to be preferred in lupus vulgaris. The cicatrization after the radium treatment is much more pronounced than either after the light or Roentgen-ray treatments, even when undertaken with all the necessary precautions.

THREE CASES OF SO-CALLED MULTIPLE IDIOPATHIC HEMORRHAGIC SARCOMA. F. PARKES WEBER, p. 309.

Weber reports in detail three cases, all of them in Hebrews of the male sex, coming from Galicia and Poland. In none of the three cases was there apparently any gout, syphilis or alcoholism.

The author's opinion as to the cause of these tumors is some local microbic infection, the cutaneous lesions representing a tissue-reaction toward the unknown invading microbes. The peculiarity of the tissue reaction lies in the new formation of dilated capillaries and lymph spaces and the proliferation of the connective tissue elements, with usually very little evidence of inflammatory cell infiltration. It is interesting in this connection to point out that in several cases the outbreak of the disease had followed a trauma.

AMERICAN JOURNAL OF SYPHILIS

(April, 1917, 1, No. 2)

Abstracted by W. H. GUY, M. D.

THE PARASITOLOGY OF SYPHILIS. HIDEYO NOGUCHI, p. 261.

An article of such volume and detail as to preclude abstraction. The reader is referred to the original contribution.

A CONTRIBUTION TO THE ACTION OF VANADIUM WITH PARTICULAR REFERENCE TO SYPHILIS, WITH A CLINICAL CONTRIBUTION. FREDERICK PROESSER, HARVEY A. SEIL AND ARTHUR W. STILLIANS, p. 347.

The various salts of vanadium were studied by animal experimentation to determine their physiologic action and therapeutic effects. It was found that the chief action of vanadium was on the vascular system with constriction of

the vessels of the lungs, spleen, kidneys and intestines, with dilatation of the superficial vessels. The flow of urine and lymph was increased. The intestinal musculature was stimulated, as was also respiration. Toxic doses produced paralysis of the respiratory and vasomotor centers, with marked fall of temperature, unconsciousness, coma and death. Albuminuria and anuria were noted, and vomiting, increased peristalsis and hemorrhagic diarrhea were also present. The dosage and toxicity for man are discussed. Marked spirocheticidal effect was noted and syphilitic lesions treated by injections of the various salts selected, retrogressed rapidly. The authors conclude that the vanadium salts have a specific effect on syphilis, clearing up clinical manifestations and favorably affecting the Wassermann reaction, but that their comparative therapeutic effects will require further study.

A PROCEDURE FOR SERUM DIAGNOSIS OF SYPHILIS ESPECIALLY RECOMMENDED FOR HOSPITAL ROUTINE. J. Bronfenbrenner and M. J. Schlesinger, p. 406.

An article presenting a technic for the serologic diagnosis of syphilis. The authors claim that many of the objections to the usual technic are overcome. The paper is given over to discussion of the details of the technic.

PALMAR SYPHILIDES. Howard Fox, p. 422.

The differential diagnosis of palmar syphilides and a description of the various types is presented. Eight excellent plates accompany the article.

A SERIES OF RUPTURED AORTIC ANEURYSMS. Paul G. Wooley, p. 426.

Nine cases are reported. The ages of the patients varied from 32 to 43 years. All were syphilitic. Of particular interest in connection with these cases is the following; in one case perforation was external through the sternum; in one into the superior vena cava; in one into the left pleural cavity by way of the diaphragm; in one it was retroperitoneal; in one into the left pleural cavity by way of the lung; in two it was into the left main bronchus; in one into the left ventricle; and in one into the pulmonary artery. Thus six sprang from the arch and two from the abdominal aorta.

SOME REMARKS ON THE SEROLOGICAL DIAGNOSIS OF SYPHILIS WITH SPECIAL REFERENCE TO THE HECHT-GRADWOHL TEST. R. B. H. Gradwohl, p. 450.

The author presents an interesting review of syphilis with particular reference to the serologic tests. The Wassermann test is analyzed and certain well defined objections and limitations are pointed out. The technic of the Hecht-Gradwohl modification of the Wassermann is given and its advantages stated. It is estimated that by the Hecht-Gradwohl test, 15 per cent. more of cases are positive than by the Wassermann, this holding particularly in the late stages of the disease when the Wassermann is not dependable.

THE INFLUENCE OF THE WASSERMANN TEST ON SURGERY. T. L. Rhoads, p. 468.

Late visceral, bone and central nervous system syphilitic lesions are those in which the surgeon will often be in doubt as to the proper diagnosis. The Wassermann test will be found to be positive in 95 per cent. of visceral lesions, in 90 per cent. of bone lesions, and in 80 per cent. with central nervous system involvement. Three negative tests, reinforced by a negative provocative Wassermann, and by a negative spinal test, if there is a history of syphilis or if there are clinical manifestations of involvement of the central nervous system, are accepted as conclusive of the absence of syphilis.

SYPHILIS OF THE DUODENUM. J. L. MORTIMER, p. 473.

Gummas are the most characteristic growth found in intestinal syphilis; there may be one or more, the size varying from a few centimeters to the palm of the hand. They are generally dirty white or yellow in color, with hard, well defined borders. A fresh gumma is more vascular than an old one, since the usual obliterating endarteritis and endophlebitis have not reached an advanced stage. Through disintegration of gummas there occur ulcers and later cicatrices. The author reports such a case. The clinical symptoms comprised epigastric pains radiating to the right side, coming on several hours after eating, nausea, but no vomiting or pyrosis; eructation of gas relieved the pain. Diagnosis was made by the history, Wassermann test and the Roentgen-ray findings and the patient recovered under antisyphilitic treatment.

EXPERIMENTAL SYPHILIS PRODUCED THROUGH LOCAL APPLICATIONS TO MUCOUS MEMBRANES. MATHEW A. REASONER, p. 478.

A rich emulsion of *Treponema pallidum* was carefully dropped on the mucous membranes of the eyes, nose and vagina; eight rabbits were treated in this manner with one positive and one doubtful result. The experiment is intended to show that it is possible to transmit syphilis through apparently normal mucous membranes.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE, DERMATOLOGY DEPARTMENT

(January, 1917, 10, No. 3)

Abstracted by W. H. GUY, M.D.

FIXED ERYTHEMA OF THE PALMS. H. G. ADAMSON, p. 61.

Report of a case.

CASE FOR DIAGNOSIS. GEORGE F. STEBBING, p. 58.

A lichen planus of unusual type.

VON RECKLINGHAUSEN'S DISEASE. J. L. BUNCH, p. 59.

Report of a case.

CASE OF EDEMATOUS SCLERODERMIA. J. M. H. MACLEOD, p. 60.

A case of unusual type, showing acanthosis and pigmentation about the elbows, axillæ, groins and neck.

LYMPHADENOMA WITH CUTANEOUS LESIONS. DUDLEY CORBETT, p. 64.

A case previously reported by Dr. Sibley. Three photographs are presented showing the generalized eruption.

SCLEREMA NEONATORUM. J. H. STOWERS, p. 68.

Sclerema involving the back and neck with subsequently a few areas on the chest and arms. The condition had been present since a few hours after birth and was improving at the time of presentation. Inasmuch as the baby had been in a state of semi-asphyxia for some hours after delivery, a possible etiological factor in pressure was suggested.

ACQUIRED SYPHILIS IN A GIRL, AGED EIGHT YEARS. H. C. SAMUEL, p. 69.

Chancre of the lip, glands of the neck, typical roseola with mucous patches in vulva and anus. Mother was a syphilitic for five years and recently gave birth to a child with congenital syphilis and the healthy daughter acquired the disease by kissing the baby.

MORPHEA-SCLERODERMIA. GEORGE PERNET, p. 73.

Presentation of a case.

PSORIASIS AND LICHEN ATROPHICUS. W. KNOWSLEY SIBLEY, p. 74.

A patient having typical psoriasis and also morphea-like lesions on the chest and arms.

SYMMETRICAL GANGRENE OF THE SKIN. W. KNOWSLEY SIBLEY, p. 76.

The lesions in this case began on the inner sides of the thighs, as blebs, spread rapidly and caused considerable superficial destruction of tissue; the colon bacillus was subsequently isolated from them.

KELOID AND URTICARIA PAPULOSA. ALFRED EDDOWES, p. 77.

A case showing a congenital tendency to keloid on slight injury, associated with urticaria papulosa.

(Ibidem, March, 1917, 10, No. 5)

A CASE OF SMALL-SPORED RINGWORM OF THE SCALP IN AN ADULT. E. G. GRAHAM LITTLE, p. 79.

CASE OF EPITHELIOMA OF THE HAND FOLLOWING TRAUMATISM. J. L. BUNCH, p. 80.

CASE ILLUSTRATING THE OXIDATION AND REDUCTION THEORY OF THERAPEUSIS. J. E. R. MCDONAGH, p. 83.

A case of mercurial poisoning cured by intramine.

LATE CONGENITAL SYPHILIS MANIFESTATIONS. GEORGE PERNET, p. 87.

A boy, aged 14, with ulceration and some destruction of the uvula and soft palate. Irregular implantation of the teeth, Olympian forehead with marked frontal bosses were noted. Severe nocturnal headaches had been present and had improved under specific medication. The duration was six months. The Wassermann was positive. The lesions healed rapidly under antisyphilitic treatment.

MEDICAL RECORD

(Mar. 10, 1917, 41, No. 10)

Abstracted by W. H. GUY, M.D.

MASSAGE IN RAYNAUD'S DISEASE (DRY GANGRENE). DOUGLAS GRAHAM, p. 402.

The author reports the use of massage of value in the therapy of the condition named in his subject.

(*Ibidem, Mar. 17, 1917, 41, No. 11*)

THE REAL CANCER PROBLEM. L. DUNCAN BULKLEY, p. 441.

The cause of cancer is due to a disturbance of metabolism which is the result of the manner of living in this modern era of advanced civilization, according to the theory of the author. He reports favorable results in treatment of certain cases by restriction to a strict vegetarian diet, outdoor exercise, regular hours, etc.—in short the avoidance of all things that might disturb metabolism, which of course, entails careful regulation of the emunctories.

With Ross of London, the author uses potassium acetate internally, because of a lack of potassium in the blood.

(*Ibidem, Mar. 31, 1917, 41, No. 13*)

SUSCEPTIBILITY TO FURUNCLE. DOUGLAS W. MONTGOMERY AND GEORGE W. CULVER, p. 533.

A series of 161 cases is studied from various angles; 70 per cent. of the cases occurred between the ages of 20 and 40 years; 57 per cent. of them were in males; sedentary occupations were found to have a distinct bearing in etiology. But little seasonal fluctuation in occurrence was noted; susceptibility and freedom from furuncle had no evident periodicity. Seventy-two occurred in the cephalic region, 37 on the body, 30 on the upper and 17 on the lower extremities; seborrhea was present in 126 cases, acne in 21, pruritic affections in 54. Concomitant pyogenic infections in 11, anemia was noted in 57, constipation in 91; in most of the cases there were found digestive disturbances and errors in diet. Indicanuria was present in 26, bile in 23. The reader is referred to the original article for much of interest.

(*Ibidem, Apr. 7, 1917, 41, No. 14*)

DIAGNOSIS OF SYPHILIS OF THE NERVOUS SYSTEM. EDWARD LIVINGSTON HUNT, p. 581.

Reliable diagnosis of syphilis requires a knowledge of facts, a clinical examination, a blood examination, a lumbar puncture, a Roentgen-ray picture and common sense.

The Wassermann and the Lange reactions are especially mentioned as of value in diagnosis.

NEW YORK MEDICAL JOURNAL

(*Jan. 27, 1917, 105, No. 4*)

Abstracted by W. H. GUY, M.D.

A CASE OF ADDISON'S DISEASE. JOS. A. MENDELSON, p. 156.

(*Ibidem, Mar. 3, 1917*)

THE DESTRUCTION OF ANGIOMAS AND OTHER NEW GROWTHS BY THE INJECTION OF QUININ AND UREA HYDROCHLORID. W. WAYNE BABCOCK, p. 385.

The author reports favorable results in angiomas, hemorrhoids, keratoses, epitheliomas, etc., by the above method.

(*Ibidem, Mar. 17, 1917*)

PREVENTION AND TREATMENT OF CANCER BASED ON ROENTGEN-RAY FINDINGS OF DENTAL INFECTION AND THE USE OF AUTOGENOUS VACCINES. SINCLAIR TOUSEY, p. 485.

A preliminary report.

(Ibidem, May 12, 1917, 105, No. 19)

INTRASPINAL INJECTIONS OF NEOSALVARSANIZED SERUM IN NERVOUS AND MENTAL DISEASES. ALFRED GORDON, p. 873.

The author concludes that the results obtained in 212 cases are bound to create a spirit of optimism in the management of syphilis involving the central nervous system. A procedure which enables us to bring spirocheticidal reagents into direct contact with the cerebrospinal system, intraspinally or intracerebrally, seems most logical, and results obtained to date indicate that future success lies in perfection of this method.

THE MODERN DIAGNOSIS AND TREATMENT OF SYPHILIS. B. A. THOMAS, p. 879.

An analysis of 557 cases with the following conclusions of note: 1. The Wassermann is the most reliable control to treatment and index of cure. 2. Early administration of salvarsan, neosalvarsan or arsenobenzol is essential for the prompt cure of early syphilis, one or two doses being sufficient to bring about a cure during the first week of the infection, in most cases. 3. Secondary syphilis may be cured without mercury by using salvarsan intensively. 4. Arsenobenzol, Canadian diarsenol, and the French preparation are inferior therapeutic agents to the German product, their relative inferiority not being marked.

FAVUS OF THE SCALP AND EYELIDS. WALTER BAER WEIDLER, p. 887.

Report of a case, describing an unusual distribution of the disease.

ARCHIVES OF INTERNAL MEDICINE

(Febrnary, 1917, 19, No. 2)

Abstracted by R. C. JAMIESON, M.D.

HEREDITARY HEMORRHAGE WITH TELANGIECTASIÁ. W. R. STEINER, p. 194.

Steiner adds a report of three families in which this interesting hemorrhagic condition is present.

Heredity he found to be the only constant factor, though other influences, such as alcoholism, syphilis and trauma, may sometimes be partially causative. Both sexes were affected almost equally and both could transmit it. Pathologically there was a loss of muscular and elastic tissue in the walls of the superficial vessels which were dilated and lined only by endothelium, being therefore especially liable to rupture.

Hemorrhage may be slight or severe, often spurting from the spots. As the patient becomes older the hemorrhage is more apt to increase in severity, cautery offering in most cases the best results.

(Ibidem, March, 1917, 19, No. 3)

ON THE RELIABILITY OF THE WASSERMANN REACTION. REUBEN OTTENBERG, p. 457.

This article is described by the author as "a study of the sources of error and an attempt to standardize the technic" and he discusses at length the various phases which have caused varying reports from different serologists.

Variation of technic was found to be a great obstacle to uniformity of results, each worker holding the idea that his method gives the best results. He considers in detail the total amount of fluids used and the primary incu-

bation—in which he believes the reagents should be incubated longer, using the icebox method with alcoholic antigens but not cholesterinated.

He does not believe the dose of antigen should be arbitrary nor should cholesterinated antigen be relied on alone for diagnosis. The cholesterinated antigen gives best results in cases under treatment as it will often give a weak positive when the simple antigen gives a negative. He treats serums which are naturally sheep hemolytic by absorption of hemolysins.

Other problems are dealt with in a minute manner and cannot be well abstracted.

THE RELATION OF PREGNANCY AND CHILDBIRTH TO PELLAGRA IN WOMEN. J. F. SILER, P. E. GARRISON AND W. J. MACNEAL, p. 404.

Pellagra was relatively less frequent during pregnancy than at other times but there was found to be increased liability to its development in the early months after childbirth. Recurrence was less during pregnancy, especially in the early months and the attacks were mild in character.

The chief significance of these observations was in regard to prognosis as well as the treatment and management of married women afflicted with pellagra.

JOURNAL OF EXPERIMENTAL MEDICINE

(March, 1917, 25, No. 3)

Abstracted by R. C. JAMIESON, M.D.

THE DRUG-FASTNESS OF SPIROCHETES TO ARSENIC, MERCURIAL AND IODID COMPOUNDS IN VITRO. SEINAI AKATSU AND HIDEYO NOGUCH, p. 349.

The writers have shown by their experiments that the varieties of spirochetes could acquire an increase of resistance to increasing doses of certain drugs. They used pure cultures of *Treponema pallidum, Treponema microdentium* and *Spirochæta refringens* while the drugs used were salvarsan and neosalvarsan, mercuric chlorid and iodin-potassium iodid, employing both liquid and solid media.

In three to four months the pallidum and microdentium increased their resistance to salvarsan and neosalvarsan five and one-half times, the refringens only three and one-half. The increase against mercuric chlorid was more pronounced, being 35 to 70 times for the pallidum, 10 times for the microdentium. Against the iodin-potassium iodid solution the increase of resistance was slight while the increases above noted did not occur when a solid medium was employed instead of a liquid.

The spirochetes lost their drug-fastness when grown again in normal media.

THE RESISTANCE OF SPIROCHETES TO THE ACTION OF HEXAMETHYLENETETRAMIN DERIVATIVES AND MERCURY AND ARSENIC COMPOUNDS. SEINAI AKATSU, p. 363.

Seventy-six new compounds were tested and found to kill spirochetes in dilutions varying from 1:50 to 1:100,000, the latter being bichlorid of mercury. The spirocheticidal property of phenol was found to be 1:2,500; lysol, 1:5,000; formalin, 1:750; salvarsan, 1:7,500; neosalvarsan, 1:2,500. Many compounds which were spirocheticidal in 1:1,000 dilution were only one-tenth that strength bactericidal against *Bacillus dysenteriæ and streptococcus,* while atoxyl was spirocheticidal in 1:50.

Spirochetes were found to undergo cytolysis with high concentrations of sodium cholate (1:5,000), sodium glycocholate and taurocholate (1:2,500) and

saponin (1:7,500). Neither sodium nor potassium iodid possessed any marked action.

THE INFLUENCE OF CARBOHYDRATES ON THE CULTIVATION OF SPIROCHETES. SEINAI AKATSU, p. 375.

Amygdalin, arabinose, beerwort, dextrin, galactose, glycogen, glucose, inulin, lactose, levulose, maltose, mannite, raffinose, saccharose and starch were added in culture media with various strains of treponemata. Glycogen and glucose inhibited the growth of spirochetes and caused an earlier degeneration. No unusual changes in the morphology of the spirochetes occurred with any of the above experimental carbohydrate media.

MUENCHENER MEDIZINISCHE WOCHENSCHRIFT

(Feb. 15, 1916, 63, No. 7)

Abstracted by ARTHUR WM. STILLIANS, M.D.

A PECULIAR, LATE SCARLATINIFORM EXANTHEM FOLLOWING TYPHOID AND CHOLERA VACCINATION. W. FRIBOES, p. 228.

A report of a series of twelve cases of scarlatiniform erythema in soldiers who had finished their immunization against typhoid and cholera three to four weeks previously. The severe cases began with a chill, followed by considerable fever (39 C. and over), sore throat, conjunctivitis, coryza and a peculiar cough. A second series of nine cases occurred later, and two cases were observed between the series. The eruption had, in the less severe cases, a yellowish pink tinge and the severe cases showed this color at the border of the patches, which were dark red in the center. The face was sometimes swollen and red, with a pale area about the mouth in two cases. The most severe case had an otitis media, an ulcerative angina and a slight albuminuria. The eruption differed from scarlatina in the color, seemed to begin on the whole trunk instead of in the infraclavicular region, and did not involve the hands and feet. No exfoliation was seen in any case, and no contagion occurred, although these cases were treated in an open ward with many others. All the cases cleared up in from three to five days.

ARSENICAL KERATOSES OR QUICKSILVER EXANTHEM? C. PHILIP, p. 231.

In answer to Wechselmann's criticism of the author's article in Vol. lxii, No. 37, of the *Muenchener medizinische Wochenschrift,* he insists that the lesions of the palms in his patient were real keratoses, appearing after the exfoliative dermatitis had cleared up. He also objects to allowing the presence of mercury in the scales of Wechselmann's case as a proof of mercurial poisoning, as mercury can be found long after an ordinary series of treatments. In answer to Wechselmann's statement that a keratosis has never been seen after salvarsan, he replies that it has also never been seen after mercury, although the number of mercury treatments far exceeds those with salvarsan, even though Wechselmann's 60,000 are counted among the latter.

THE TREATMENT OF SKIN DISEASES WITH THIGASIN. E. FRAENKEL, p. 254.

Thigasin is a thigenol ointment to which acetone-chloroform has been added. The author has found it very useful in itching dermatoses.

(*Ibidem, Feb. 22, 1916, 63, No. 8*)

EXPERIENCES WITH SALVARSANNATRIUM IN CONCENTRATED SOLUTION. A. SCHMITT, p. 270.

In the experience of the author it is possible to use salvarsannatrium safely in concentrated solution in distilled water. He has given 57 injections of 0.3 gm. in 10 c.c., and 20 injections of 0.45 gm. in 10 c.c. Only in two cases was there any material rise of temperature, and these had mild reactions. One case had a phlebitis, both proximal and distal to the point of injection. The author thinks that this may have been due to failure to loosen the constrictor fully.

(*Ibidem, Feb. 29, 1916, 63, No. 9*)

TYPHOID AND PARATYPHOID ROSEOLA. E. FRAENKEL, p. 325.

Over fifteen years ago the author made his first histologic study of the rose spots of typhoid and by incubating the biopsy material in bouillon, succeeded in proving the existence of typhoid bacilli in the rose spots, as well as obtaining a more complete study of their other histologic peculiarities. In any one lesion only a few of the papillæ are affected, sometimes only one. The affected papillæ are more or less swollen and show an increase of the fixed connective tissue cells. No leukocytes or lymphocytes are seen, but groups of typhoid bacilli are found in the lymph spaces. The capillaries are dilated. In some instances the process is severe enough to cause necrosis of the papilla and overlying epidermis. The same is true of the fading rose spot. In an eleven day old lesion, a maculo-papule, a small collection of the bacilli was found between the dermis and epidermis. The author suggests the possibility that during the fine exfoliation following the eruption, living typhoid bacilli might be excreted in this way and spread the infection.

He examined in the same way a lesion from a case of paratyphoid, and found the bacilli in great numbers in the lymph spaces, while the tissue reaction was much milder than in the typhoid lesions, only an edema of the papillæ without cell infiltration.

(*Ibidem, Mar. 7, 1916, 63, No. 10*)

BLOOD CHANGES AFTER RADIATION WITH MESOTHORIUM. B. SCHWEITZER, p. 341.

The cases of pelvic carcinoma on which these observations were made all had secondary anemia and many had slight leukocytosis and eosinophilia before the treatment was begun. All cases received large doses of the radiation, between 900 and 1,500 milligram-hours, through a brass filter, 1.5 mm. thick. A few cases were too near death to show any benefit from the treatment. All the others showed, soon after the treatment, an increase of hemoglobin and red cells, probably as a result of the cessation of hemorrhage. The leukocytes increased very soon up to 12,000, on the average, about 3,000 more than the average count before treatment. Within twenty-four hours the count had returned to its former number and in forty-eight hours was below this figure. Three or four weeks after the first series of treatments, aggregating 2,600 to 4,900 milligram-hours, the white cells were still few, from 3,000 to 6,000.

The initial increase was in the neutrophils, which later fell below the normal percentage. The lymphocytes and eosinophils were diminished immediately after the exposure, later to increase above the normal. The author is convinced that this disturbance of the whole number and the relative percentages of the various kinds of white cells is a temporary condition of no importance to patients receiving treatment for a limited time. It is of great importance to radiotherapeutists, however. Previous reports have not carried the blood counts more than a week after the end of treatment. The author finds the disturbance of the white count very regularly at the end of the third or fourth week after treatment. He believes that the lymphocytes are destroyed in the

blood stream by the direct action of the rays, the reaction to this resulting in overproduction later.

CARCINOMA OF THE BACK OF THE HAND ON THE SCAR OF AN OLD GUNSHOT WOUND. E. MELCHIOR, p. 371.

The patient, as a boy of 9 years, received a pistol wound in the hand in the Revolution of 1848. After this scar was 68 years old, a carcinoma developed, necessitating an amputation of the forearm. The author recalls the case reported by Coenen in which a scar of 47 years' standing was the site of a carcinoma. This was, like Melchior's case, also on the back of the hand.

(*Ibidem, Mar. 28, 1916, 63, No. 13*)

THE TREATMENT OF LOCALIZED TUBERCULOSIS WITH LECUTYL AND ARTIFICIAL SUNLIGHT. A. STRAUSS, p. 449.

Lecutyl is a stannate of copper and lecithin. It has given good results when administered by mouth and percutaneously to patients with internal foci of tuberculosis, but when it can be applied locally it is much more active. The author mentions a case of tuberculous caries of the femur healed in two months' treatment and remaining well for over four years, an extensive lupus vulgaris of the arm cured after several courses of treatment, and a very extensive lupus vulgaris of the face, ears, chest and neck, also cleared up. But the drug alone is insufficient for many cases, and the combination of lecutyl and quartz lamp treatment is especially recommended. Dressing of the lesion with the drug, two or three times a week, and a more or less general exposure of the body to the quartz lamp from two to six times a week, have given good results in many cases. The dressing is left in place during the exposure to light, in order to protect the lesion. The author explains the results by the theory that the general exposure of the skin to light is productive of pigment, the excess of which is carried by the red cells to the cells of the lesion, here causing a local reaction like that due to tuberculin. This reaction he has seen in cases which had only general exposures to the light, no local treatment, and the lesion protected from the light. Oxidation is increased, and the production of red cells and hemoglobin stimulated by the light, while the skin temperature is raised at the same time that the inward temperature is lowered. This effect he aids by the use of incandescent light, "red, deeply penetrating rays," as he calls them.

To this effect of light is added the local effect of a copper salt, which also has been shown to cause a reaction very like the local reaction of tuberculin. It is an active antiseptic, increases oxidation and assists the action of light in the production of pigment, just as arsenic does. Thus the two agents work together to resolve the tuberculous tissue, destroy the toxins, produce an unfavorable soil for the growth of the bacilli, increase metabolism, improve the general health and perhaps aid immunization. The general effect of light is much preferable to its local action, because it is specific, while the local action is not.

CONCERNING THE CONFUSION OF QUICKSILVER AND SALVARSAN ERUPTIONS. WECHSELMANN, p. 458.

To Neisser the author replies that he never has denied that a salvarsan exanthem occurs. On the contrary, he described cases in 1910 and 1911. But he has never seen edema and infiltration of the skin, such as Neisser describes as "arsenic exanthem." These resemble mercury dermatitis very closely, and he suggests that it would be of great value if Neisser would report his cases. He accuses Philip of changing the description of the palmar lesions in his case, and says that the testimony in favor of their being arsenical keratoses is of no value because of poor description.

THE WAVE LENGTH OF THE ROENTGEN RAYS AS A MEASURE OF PENETRABILITY. A. SOMERFELD, p. 458.

The author gives the additions to our knowledge of the atom resulting from our ability to measure the wave lengths of Roentgen and gamma rays by means of crystals. He explains the shortcomings of the Wehnelt and Benoist penetrometers as due to the fact that silver has an increased absorption for all wave-lengths under 0.049 micro-microns, so that these instruments are not to be depended on for measurements of rays of very short wave-lengths. He suggests that in the future tubes may be graded according to the average wave length of their radiations, instead of roughly as soft, medium and hard. This is a very interesting article.

DEPARTMENT OF PUBLIC CHARITIES, NEW YORK CITY HOSPITAL BULLETIN

(January, 1917, No. 2)

Abstracted by OSCAR L. LEVIN, M.D.

AN UNUSUAL FORM OF MYCOSIS FUNGOIDES. WILLIAM S. GOTTHEIL, p. 89.

The patient, a male German, aged 30, first noticed the eruption on his arms and legs fifteen years ago. This consisted of small red spots covered with fine white scales. After persisting for several weeks these would fade, to leave pigmented areas which would gradually disappear. New lesions would appear from time to time. A similar eruption appeared on the trunk, six years ago.

The scalp condition appeared two years ago as a small, white, scaly area which extended slowly to the present size. Moisture was first manifested nine months ago.

When admitted to the City Hospital there was an eruption on the extremities and trunk, consisting of pinhead-sized, bright red, slightly elevated papules, covered with fine, white, fairly adherent scales. In places the papules were confluent and formed large, dark red, infiltrated patches. The eruption on the trunk and extremities presented, on the whole, the appearance of a chronic seborrheal eczema. The right side of the scalp was devoid of hair, bright red, swollen and in places moist. The affection also involved the right forehead and temple.

The diagnosis of mycosis fungoides was made after an examination of the tissue removed from the extremities and scalp.

The article is accompanied by a photograph showing the extent of the lesion on the scalp and face. There is also a microphotograph of a section from the scalp, showing the dense infiltration in the corium.

THERAPEUTIC GAZETTE

(Jan. 15, 1917, 41, No. 1)

Abstracted by OSCAR L. LEVIN, M.D.

CARDIAC SYPHILIS. THOMAS E. SATTERTHWAITE, p. 4.

Syphilis of the heart begins in the vessels and perivascular tissues and produces a progressive induration of the interstitial tissue. The lesions resemble those of tuberculosis and it is impossible to distinguish between the two when

bacilli and spirochætes are not found. Endocarditis, pericarditis or myocarditis occurring in syphilis, when found at autopsy, is likely to be attributed to something other than syphilis, except when gummas or a marked fibroid infiltration are present.

The clinical diagnosis of cardiac syphilis depends on a previous history of syphilis, arteriosclerosis, a weak, frequent or infrequent arhythmic pulse, dilated heart, angina, aortic dilatation, or aneurism; valvular disease, usually aortic; finally the Wassermann or other syphilitic reaction. The therapeutic test is also of value.

Cardiac symptoms are present in most cases of syphilis; though they may appear in the second stage, they usually are not discovered until the third stage.

Not only is syphilis a more common disease than previously suspected but in a certain number of cases it is the actual cause of death from heart implication. Cabot reported syphilis as the cause of death in 13 per cent. of 562 cases of heart failure; Breitmann, Mraçek and Julien have made it 33 per cent. As a result of his own experience, the author concludes that syphilis is the cause in 10 per cent. of the cases of heart disease.

The prognosis of cardiac syphilis is always bad. The best results are obtained when the diagnosis is made early and the proper treatment immediately instituted. A cure may be possible, while relief is probable, if the lesion is not too far advanced.

Treatment consists in the administration of salvarsan, mercury and iodids until the Wassermann reaction becomes negative. The usual treatment for cardiac disease is then given.

MEDICAL JOURNAL OF AUSTRALIA

(Jan. 6, 1917, No. 1)

Abstracted by OSCAR L. LEVIN, M.D.

A CASE OF EPITHELIOMA ADENOIDES CYSTICUM (BROOKE). NORMAN PAUL, p. 8.

The author reports a case of this disease, occurring in a female, aged 37. A similar condition was present in the father, grandfather and two younger members of the family. In every case the condition had started about the time of puberty.

The lesions varied from millet-seed sized to a little smaller than hemp-seed sized papules. They were firm to the touch, somewhat more translucent than the normal skin and a few showed dilated capillaries. The eruption was symmetrical and distributed at the inner canthi of the eyes, along the nasofacial folds and on part of the upper lip. There was no tendency to breaking down.

MEDICAL REVIEW OF REVIEWS

(February, 1917, 23, No. 2)

Abstracted by OSCAR L. LEVIN, M.D.

THE TREATMENT OF ECZEMA. OSCAR L. LEVIN, p. 120.

This article is an outline of the general plan followed in the treatment of eczema. Treatment consists in: first, the removal or correction of any local or general predisposing factor; second, the detection and removal of any direct external or internal excitant and third, the restoration of the normal local structure and function.

It is emphasized that water is not always harmful in eczema but it is often of distinct value. Water may do injury by prolonged soaking and subsequent maceration of the skin or by virtue of the presence of chemicals and irritants.

REVISTA ESPANOLA DE UROLOGIA Y DERMATOLOGIA

(January, 1917, 19, No. 217)

Abstracted by VICENTE PARDO, M.D.

TUBERCULOSIS AND PSORIASIS. BELISARIO GALLEGO, p. 5.

The author supports the view that psoriasis is indirectly due to tuberculosis or a para-tuberculosis, like lupus erythematosus. He quotes an article written by Sabouraud and published in the *Presse Medicale*, in which the author remarks the frequent coexistence of psoriasis and tuberculosis in the same patient; "psoriasis may be a cutaneous manifestation of larvate tuberculosis of slow evolution which never kills the patient. . . . I believe that the tuberculous origin of psoriasis ought to be taken into consideration and experimentally studied and investigated." Gallego ends his article recommending the tuberculin treatment of psoriasis.

(Ibidem, February, 1917, 19, No. 218)

IMPORTANCE OF DETERMINING THE HEMOLYTIC INDEX OF THE SERUM IN THE SERUM DIAGNOSIS OF SYPHILIS BY THE WASSERMANN TEST AND ITS DERIVATIVES. L. DEL PORTILLO, p. 61.

It is known that human serum contains a certain amount of specific anti-sheep amboceptor, capable of hemolysing from 0.1 to 2 c.c. of a 5 per cent. suspension of erythrocytes. The author calls attention to the fact that this amboceptor is not at all considered in the original Wassermann test and not carefully titrated in its derivatives, wherefrom the most inaccurate results are likely to occur. He thinks that in the performance of the complement fixation tests, the hemolytic amboceptor should be titrated in every serum.

SIX YEARS OF ARSENICAL THERAPY OF SYPHILIS. J. PEYRI, p. 64.

Since the discovery of salvarsan by Ehrlich, the author has been experimenting with this drug and its derivatives. He begins his article recalling that all arsenic preparations, including salvarsan and neosalvarsan, are incapable of achieving the "therapia sterilisans magna," but the remarkable results clinically obtained with these drugs on the actual syphilitic lesions justify their wide use. The author's experience has been with salvarsan, neosalvarsan and arsenobenzol (Billon) and from a total of 1,000 injections he concludes that there is no difference in these products so far as the clinical results are concerned; nevertheless, he prefers salvarsan to the other compounds on account of its quicker action.

The author has treated a few cases (eight) with galyl (Mouneyrat), and concludes that its action is similar to that of salvarsan, but he is unable to reach final conclusions with such a small number of cases. The drugs known under the names of 1116, ludil and 1151 are also considered, but the author has not had any experience with them.

The early and late accidents of arsenical therapy are studied in a total of 2,091 patients, with 4,103 injections. Among the first he has observed: syncope, fever, gastro-intestinal disturbances and the nitritoid reaction, due to the vaso-

dilator effect of the drug. Among the latter: neuritis and the so-called nervous relapses with meningeal lesions.

Three cases ending in death are described; one died three days after the injection from a serous encephalitis, another died six days after the injection with respiratory phenomena and a third one died after the second injection, with the classical symptoms of arsenic poisoning.

As for the contraindications, the author discards nephritis and optic neuritis and believes that all these cases improve with salvarsan; only the cardiac and vascular lesions are considered as contraindications to intravenous salvarsan therapy.

GIORNALE ITALIANO DELLE MALATTIE VENEREE E DELLA PELLE

(Feb. 12, 1917, 51, No. 6)

Abstracted by Vicente Pardo, M.D.

VITILIGO AND SYPHILIS. Vignolo-Lutati, p. 317.

The relation of vitiligo to syphilis has been a matter of much discussion. There is undoubtedly a specific leukoderma or syphilitic vitiligo which appears during the second stage of the disease, most particularly in women, and which is but little influenced by specific therapy. The etiology of vitiligo is up to the present unknown; Brocq thinks it is of nervous origin and says: "The affection is brought about by a shock, an injury and also appears in syphilitics and after violent neuralgias." Several authors, among them Pierre Marie and Darier, lay great importance to syphilis in its relation to vitiligo and have reported several cases in which syphilis was the etiologic factor in vitiligo. The author groups the pigmentary lesions of syphilis, according to Pautrier, as follows: first, primary lesions appearing as sole manifestations on the skin (melanodermia syphilitica of the neck, melanodermies atypiques of Fournier, and leukomelanodermie of Fournier); second, pigmentations appearing as a consequence of previous syphilitic lesions (hyperpigmented spots, brown or black in color, on the sites formerly occupied by papules, pustules, gummas, etc.); apigmented spots known under the name of leukoplakia syphilitica and white patches, surrounded by a dark or blackish ring.

Edward H. Marsh in America and Gouguerot and Guggenheim in France, have reported cases of syphilitic vitiligo, the etiology of which was beyond question. As for the mode of action of the syphilitic virus, it is thought that the spirochete may produce lesions of the suprarenal glands and hence disturbances in the regular distribution of the pigment in the skin. The author describes five cases of vitiligo associated with different forms of syphilis (vitiligo and tabes, vitiligo and heredo syphilis and vitiligo and syphilid tuberosa), and finally says that vitiligo is not due to a single etiologic factor but that syphilis must be considered as a direct causative of the dyscromia in many cases.

Correspondence

To the Editor:

Dear Sir:—In an excellent article on phenol in the March issue of The Journal, by Douglas W. Montgomery, he remarks on page 161 that, "Neither camphor nor its allied substance, menthol, may be prescribed as solutions in eczema (as an antipruritic), because of being insoluble in water. The alcoholic solutions naturally cannot be used."

Nevertheless, the following formula is being used as an antipruritic, with marked benefit, in many dermatoses accompanied by pruritus, including eczema. The only exceptions being moist and ulcerative conditions of the skin.

℞ Menthol .....
Resorcin .....āā 0.5 to 2.0
Alcohol, pure.....
Distilled water.....āā, ad 100.0

M. Sig.: External use; to mop on with cotton.

This gives a perfectly clear solution, provided it is made in the following way. The menthol and resorcin are added to the pure alcohol until complete solution takes place and then the distilled water is added, using the amounts as given above. If more water is added the menthol is thrown out of solution.

Various other soluble ingredients may be added or substituted when necessary, such as camphor, phenol, salicylic acid or antipyrin, etc., but not stronger than 2 per cent.

E. Wm. Abramowitz, M.D.,
Assistant Attending Dermatologist, Vanderbilt Clinic, Columbia University.

Book Reviews

THE INTERNAL SECRETIONS. By E. Gley, M.D., Professor of Physiology in the College of France; Member of the Academy of Medicine of Paris, etc. Translated from the French and edited by Maurice Fishberg, M.D., Clinical Professor of Medicine, New York University and Bellevue Hospital Medical College; Attending Physician, Montefiore Home and Hospital for Chronic Diseases. *Paul B. Hoeber Company, New York,* 1917. (241 pages.)

To the average physician the subject of the internal secretions seems to be somewhat involved, entirely theoretical and of little practical importance. The small volume by Dr. Gley supplies a concise, logical and practical consideration of the subject. Particular stress is laid on facts of practical application in the treatment of disease. The origin and development of our conception of the internal secretions is given considerable space in the first part of the book, the historical notes of which may or may not seem tedious to the reader.

Each "patron saint" of the internal secretions is given his "place in the sun." The distinctive characteristics of the internal secretory glands are considered. The author offers objection to the indiscriminate therapeutic use of organic extracts. The latter part of the book is devoted to a discussion of the physi-

ology of the internal secretory glands, particular attention being directed to their reciprocal activities in health, the diseased function being also discussed.

Conservative in tone, presenting facts as well as plausible theories, this small volume commends itself to the physician who, lacking time to read extensive works, desires a working knowledge of the endocrinous glands and their secretions. W. H. G.

GRANULOMA VENEREO. By H. C. de Souza Araujo. A monograph. 246 pages. 1917. Rio de Janeiro, Brazil.

There are about twenty-two different names for this disease, the most common being "ulcerating granuloma of the pudenda" and "granuloma venereo." Granuloma venereo is a chronic vegetating or ulcerating dermatosis affecting chiefly the external genitalia and the perigenital regions. It was first described in 1882 by K. MacLeod. Conyers and Daniels, Galloway, Donovan, Aragao, the author, and others have also studied it. It is not a tropical disease, it is universal, and has been encountered in India, the Pacific Islands and South America (where the disease is prevalent); it is also common in Africa and several cases have been observed in Europe and in the United States.

Granuloma venereo has been considered as a manifestation of syphilis, tuberculosis, frambœsia, staphylococcia, phagedænia, mycosis, etc. It is really a bacterial disease caused by the *Calymatobacterium granulomatis,* discovered by Donovan in 1905. This germ is always present in the lesions and reproduces the disease experimentally. Treponema and spirilli have been found in the lesions, though not in all cases. Association with syphilis has been detected in several cases; also with soft chancre. The author establishes the following conclusions: the *Calymatobacterium granulomatis* is the specific germ of this disease because it has been found in all cases, it has been isolated and pure cultures have been obtained, experimental inoculations of mice and guinea-pigs have always been positive and the germ has been re-isolated from the animal; after healing of the lesions, the germ cannot be found in any part of the organism. The climate has no influence whatever on the disease. It attacks the colored race as well as the white, though some authors express the opinion that colored races are more susceptible. The age of the patient varies from 20 to 50 years; few cases in children have been recorded. The disease is transmissible and generally it occurs through sexual intercourse. Several cases presented extragenital lesions, caused probably by autoinoculation with the hands. Usually the persons attacked belong to the lowest social class, therefore cleanliness is an essential factor in preventing the disease.

The *Calymatobacterium granulomatis* belongs to the group of capsulated organisms, together with the pneumobacillus of Friedländer, the pneumococcus and *Bacillus aerogenes capsulatus.* It is a bacillus, one and a half microns long, oval shaped and with a very distinct capsule; it grows at room temperature as well as in the incubator at 37 C., on Sabouraud medium and agar especially. The best stain is Giemsa with which the bacillus is stained purple and the capsule light pink. The Gram stain is negative. The microörganisms may be detected in the serous discharge from the lesions and in the sections. They are usually arranged in rows and sometimes in zoögleæ.

The best animals for experimental work are mice, guinea-pigs being less susceptible. Mice die generally between twenty-four and forty-eight hours after an injection of 1 c.c. of the bacterial culture. Septicemia is the most common cause of death in animals and sometimes a subcutaneous nodule appears at the point of injection and the animal dies from cachexia, after several days. The Wassermann test is always negative in pure cases of granuloma. Biologic reactions, viz., agglutination, complement fixation, etc., are always negative.

Granuloma is a type of infectio-contagious tumor (Siebert). The pathologic changes begin in the derma, around the vessels, with a very thick round cell and plasma cell infiltration. The epidermis is secondarily attacked and destroyed. Giant cells are present now and then. In the epidermis the changes are at

first marked acanthosis with parakeratosis; when the epidermis is destroyed, the papillomatous subepidermic formations become naked, in the form of small, prominent, red and very friable tumors.

The disease begins as a small papule or pustule in or about the genitalia. The incubation period varies from eight days to one month. The initial lesion grows subcutaneously and finally breaks out and forms a papilloma or a small ulceration which spreads eccentrically in serpiginous form. There can be detected three stages: 1, initial lesion; 2, ulceration; 3, cachexia and death or retrogression and recovery. The author describes three clinical forms: ulcerating, hypertrophic and ulcerating-hypertrophic. The differential diagnosis must be made with syphilis, tuberculosis, ulcus molle, ulcus tropicum, condyloma acuminatum, frambœsia, leprosy, actinomycosis, blastomycosis and sporotrichosis. The prophylaxis is based on cleanliness and quick treatment and isolation of the patients.

Surgical treatment, heat, light, cautery, etc., have been employed without success. Roentgen-ray treatment has proved useful and the author employs it in some cases. The treatment of choice is that by tartar emetic. They employ a 1 per cent. solution of this salt in normal saline and inject 5 c.c. of it intravenously every day. The drug is well supported and no distressing results have been observed. Generally, after five or six treatments the lesions begin to subside and the cure is complete after ten to forty injections, depending on the gravity of the disease. Trials of vaccine therapy and serotherapy have absolutely failed.

Thirty-two cases of granuloma venereo are described by the author.

V. P.

A TREATISE ON DISEASES OF THE SKIN FOR ADVANCED STUDENTS AND PRACTITIONERS. By HENRY W. STELWAGON, M.D., PH.D., Professor of Dermatology in the Jefferson Medical College; Consultant to the Dermatological Department of the Philadelphia General Hospital, to the Howard Hospital, to the Pennsylvania Institution for the Deaf and Dumb, to the Pennsylvania Institution for Feeble-Minded Children and to the Widener Memorial Training School for Crippled Children; Member of the American Dermatological Association; Honorary Member of the Society of Dermatology and Syphilography of France, of the Vienna Dermatological Society and of the Berlin Dermatological Society. Eighth Edition, revised. *W. B. Saunders Company*, 1916. *Philadelphia and London.*

Students and practitioners of dermatology are indebted to Dr. Stelwagon for his tireless energy and genius in not only writing a splendid textbook, but in keeping it up-to-date by numerous editions. The orderly manner in which the various subjects are presented, the completeness of the text, the up-to-date bibliography and numerous illustrations, not to mention the attractive appearance of the book, make it invaluable to all students of dermatology. In the present (the eighth) edition, the author has included the following new subjects: occupational dermatoses, paraffinoma, purpura annularis telangiectodes, xanthoma elasticum and ulerythema ophryogenes, while the following topics that have been revised or fully discussed include pellagra, angioma serpiginosum, erythema elevatum diutinum, pemphigus neonatorum (impetigo contagiosa bullosa neonatorum) leprosy, the leukemias, eczematoid ringworm, coccidioidal granuloma and others. Among the 356 text illustrations and 33 colored and half-tone plates, 35 are new. The references to the literature, which are numerous, are conveniently placed as footnotes instead of at the end of each chapter. As in the previous edition, the work of the publishers is all that could be desired, the glazed paper being especially suited for the numerous illustrations scattered through the text.

H. F.

COLD IN DERMATOLOGY. LIQUID AIR. CO_2 SNOW. By JOAQUIN CERVERA. *Buenos Aires,* 1916. A monograph, 94 pages.

The author recounts the history of liquid air and carbon dioxid snow and reminds us that both were American discoveries. A condensed and very practical study on the technic of liquid air is given. Liquid air is very difficult to keep on account of its low temperature and high power of expansion when it becomes gaseous; it is also difficult to handle for it evaporates quickly and is capable of producing grave burns on the hands of the operator. The author keeps it in a Dewar's bottle, unstoppered. Liquid air is expensive, another inconvenience to count with.

Carbon dioxid snow has been employed by the author with practically the same results as with liquid air, with less danger and less cost. He describes several apparatuses and the technic for obtaining it. The microscopic changes pointed out by the author as a result of the action of carbon dioxid snow on the skin, are those of acute edema and congestion. Among his clinical observations he claims success in the treatment of cases of epithelioma of the face, lupus erythematosus, tuberculosis verrucosa, verruca vulgaris, verruca plana juvenilis, acne necrotica, hydro-adenoma, granulosis rubra nasi and blastomycosis.

V. P.

TOXIN THERAPY AND VACCINE THERAPY OF LEPROSY IN MEXICO. J. GONZÁLEZ URUENA. *Mexico,* 1916. A pamphlet, 12 pages.

The author has treated several leprosy patients with Rost's "leproline," imported from Bombay. "Leproline" is a bouillon culture of Hansen bacilli kept in the incubator for seven weeks and then filtered and sterilized at 80 C. He made several cultures in agar and prepared a vaccine which he named "leproline R. P.," in the following manner: 1, washing of the cultures with normal saline solution, collecting the fluid in a sterile flask; 2, bacterial count per c.c. (titration); 3, sterilization; 4, distribution of the vaccine in small ampules, adding 0.25 per cent. lysol. The dose of this vaccine, injected, was 1 c.c. every week.

The cases treated by Uruena were six, all of them natives, the clinical type of leprosy being nodular, nervous and mixed. No practical result was obtained; the patients remained in the same condition, without visible improvement.

V. P.

Resolutions

On Jan. 3, 1916, George Thomas Jackson, for many years an honored and respected member of this Association and its one-time president, passed from this life.

Dr. Jackson had his early education in the schools and colleges of the city of New York, and received his degree in medicine from the College of Physicians and Surgeons in 1876. Following this, he spent two years in post-graduate study and practice in Berlin, Strassburg and Vienna. On his return to this country, he devoted himself to the study and practice of dermatology, and soon arose to a respected and eminent place among his fellow specialists. Dr. Jackson was consulting dermatologist to many of the larger hospitals in New York. He was a member of the New York and American Dermatological Associations, and was a member of the editorial board of THE JOURNAL OF CUTANEOUS DISEASES. From 1908 to 1913, he occupied the position of Professor of Dermatology at the College of Physicians and Surgeons in Columbia University.

Dr. Jackson's contributions to dermatology took the form of several articles and three books. The first of the latter, published in 1887, was on "Diseases of the Hair and Scalp." In 1912, in conjunction with the late Dr. Charles McMurtry, he published a "Treatise on Diseases of the Hair." His "Handbook on Diseases of the Skin" went through seven editions.

WHEREAS, In Dr. George Thomas Jackson the American Dermatological Association has lost one of its oldest and most respected members; and

WHEREAS, The members of the Society have lost in Dr. Jackson a man of exceptional character and attainments; be it

Resolved, That the Association expresses its sense of loss in these resolutions on its minutes; and be it further

Resolved, That a copy of these resolutions be sent to Dr. Jackson's family as an expression of sympathy for them in their bereavement and as an indication of the great esteem in which the Association held him.

Notice

ORGANIZATION OF THE AMERICAN ASSOCIATION FOR THE CONTROL OF SYPHILIS

There was organized at Cincinnati, on May 23 and 24, 1917, the "American Association for the Control of Syphilis," the objects of the Association to be the promulgation of knowledge of syphilis among medical men, medical institutions, boards of health, hospital boards, dispensary attendants and boards, and other organizations having the care and treatment of syphilis.

Those composing the charter membership hope to develop the important social and economic sides of this disease. Plans are also being made to collect standardized statistics from the various institutions now treating syphilis; to further the establishment of free clinics and dispensaries for the diagnosis and treatment of syphilis, and to encourage the more comprehensive teaching of syphilis in medical schools.

The Association will operate through a national body and local branches in various cities, probably in close coöperation with the American Social Hygiene Association, the former to interest themselves in the purely medical side of the work which is not entirely covered by the latter Association.

The membership of the Association at present is composed of the following:

W. T. Belfield, Chicago
Ernest D. Chipman, San Francisco
W. T. Corlett, Cleveland
Isadore Dyer, New Orleans
M. F. Engman, St. Louis
J. A. Fordyce, New York
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H. W. Stelwagon, Philadelphia
G. H. Walker, Baltimore
Grover Wende, Buffalo
Udo Wile, Ann Arbor
J. M. Winfield, Brooklyn
H. R. Varney, Detroit

The following officers were elected: M. F. Engman, president; J. F. Schamberg, vice president; H. E. Kleinschmidt, secretary and treasurer, 607 Federal Reserve Bldg., St. Louis.

The Journal
of
Cutaneous Diseases
INCLUDING SYPHILIS

THE JOURNAL, ever since its first issue, in 1884, has been the representative dermatological journal of America.

THE JOURNAL was purchased by the American Dermatological Association and passed into its control in January, 1912.

When THE JOURNAL became the official organ of the American Dermatological Association it was enabled to offer its readers the complete yearly transactions of this body. This required a great deal of space, and room was made for the many worthy independent contributions by increasing the size of THE JOURNAL.

The character of the mechanical work on THE JOURNAL—printing, illustrations, stock, etc., is the best that can be attained.

A new feature that should be of great interest and value to our readers is the New Abstract Department. Every issue of every dermatological journal in the world, and all articles of interest to the dermatologist, appearing in general medical journals and journals of the various medical specialties, of all countries, will be carefully, completely and promptly abstracted. In addition, about every second or third issue will contain a special review of some important topic, as, for instance, salvarsan, sporotrichosis, radiotherapy, the Wassermann reaction, etc. Also each issue will contain special articles on histopathology, pathology, etc.

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CONTENTS

ADDRESS

PRESIDENTIAL ADDRESS. TWENTY-FOURTH ANNUAL MEETING OF THE AMERICAN DERMATOLOGICAL ASSOCIATION. A. RAVOGLI, M.D. 567

ORIGINAL COMMUNICATIONS

A CASE OF MULTIPLE BENIGN TUMOR-LIKE NEW GROWTHS OF SCHWENINGER AND BUZZI. WILLIAM ALLEN PUSEY, M.D. 582

THE ELECTRIC CAUTERY IN CUTANEOUS SURGERY. H. H. HAZEN, M.D. 590

FURTHER STUDIES ON THE MODE OF ABSORPTION OF MERCURY IN THE INUNCTION TREATMENT OF SYPHILIS. UDO J. WILE, A.B., M.D., AND JOSEPH A. ELLIOTT, A.B., M.D. 594

EXPERIENCE WITH THE COOLIDGE TUBE IN THE TREATMENT OF NON-MALIGNANT DISEASES OF THE SKIN. HOWARD FOX, M.D. 599

SOCIETY TRANSACTIONS

NEW YORK DERMATOLOGICAL SOCIETY, DEC. 19, 1916 605

CHICAGO DERMATOLOGICAL SOCIETY, NOV. 21, 1916 608

REVIEW OF DERMATOLOGY AND SYPHILIS

BRITISH JOURNAL OF DERMATOLOGY. I. ROSEN, M.D. 615

AMERICAN JOURNAL OF SYPHILIS. W. H. GUY, M.D. 616

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE, SECTION ON DERMATOLOGY. W. H. GUY, M.D. 618

MEDICAL RECORD. W. H. GUY, M.D. 619

NEW YORK MEDICAL JOURNAL. W. H. GUY, M.D. 620

ARCHIVES OF INTERNAL MEDICINE. R. C. JAMIESON, M.D. 621

JOURNAL OF EXPERIMENTAL MEDICINE. R. C. JAMIESON, M.D. 622

MÜNCHENER MEDIZINISCHE WOCHENSCHRIFT. ARTHUR W. STILLIANS, M.D. .. 623

DEPARTMENT PUBLIC CHARITIES, NEW YORK CITY, HOSPITAL BULLETIN. OSCAR L. LEVIN, M.D. 626

THERAPEUTIC GAZETTE. OSCAR L. LEVIN, M.D. 626

MEDICAL JOURNAL OF AUSTRALIA. OSCAR L. LEVIN, M.D. 627

MEDICAL REVIEW OF REVIEWS. OSCAR L. LEVIN, M.D. 627

REVISTA ESPANOLA DE UROLOGIAY DERMATOLOGIA. VINCENTE PARDO, M.D. ... 628

GIORNALE ITALIANO DELLE MALATTIE VENERE E DELLA PELLE. VINCENTE PARDO, M.D. 629

CORRESPONDENCE

LETTER FROM E. W. ABRAMOWITZ ON PHENOL 630

BOOK REVIEWS

THE INTERNAL SECRETIONS. E. GLEY, M.D. 630

GRANULOMA VENEREO. H. C. DE SOUZA ARANJO, M.D. 631

DERMATOLOGY. EIGHTH EDITION. HENRY W. STELWAGON, M.D. 632

COLD IN DERMATOLOGY. JOAQUIN CERVERA, M.D. 633

TOXIN THERAPY AND VACCINE THERAPY OF LEPROSY IN MEXICO. J. GONZÁLEZ URUENA, M.D. 633

RESOLUTIONS

IN MEMORY OF GEORGE T. JACKSON, M.D. 633

NOTICE

AMERICAN ASSOCIATION FOR THE CONTROL OF SYPHILIS 634